UnitedHealthcare
185 Asylum Street
Cityplace I
Hartford, CT 06103

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BUSINESS TRANSFORMATION INSTITUTE, INC.
10630 LITTLE PATUXENT PARKWAY
SUITE 405
COLUMBIA, MD 210440000

Dear Customer:

The Affordable Care Act requires all health plan issuers and group health plans to provide eligible enrollees with a Summary of Benefits and Coverage (SBC). The SBC provides you information to better understand your plan and allows you to compare coverage options.

You are receiving this package due to one of the following plan coverage events that requires you to receive an SBC.

- Upon application for coverage,
- Prior to any material modification of your plan coverage,
- Prior to your plan renewal, or
- You are a special enrollee.

If you are an Employer, you can find your group's SBC documents by logging into www.employereservices.com and select "Summary of Benefits and Coverage" under the Resources menu.

For more information regarding this document, please visit uhc.com/summary or contact the Member Services number on the back of your ID card.

Very truly yours,

Andrew R Heim

Andrew R Heim
UnitedHealthcare

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.myuhc.com** or by calling **1-866-673-6293.**

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	Network: $1,500 Indiv* / $3,000 Family Per policy year. Does not apply to services listed below as "No Charge". * Doesn’t apply if policy covers 2+ people.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other **deductibles** for specific services?	No, there are no other deductibles.	You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an **out of pocket limit** on my expenses?	Network: $3,000 Indiv* / $6,000 Family * Doesn’t apply if policy covers 2+ people.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is **not included in the out of pocket limit**?	Premium, balance-billed charges, health care this plan doesn’tcover.	Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**.
Is there an overall **annual limit** on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of providers?	Yes.This plan uses network providers. For a list of network providers, see www.myuhc.com or call 1-866-673-6293.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn’t cover are listed on page 5 or 6. See your Policy or plan document for additional information about **excluded services**.

- **Co-payments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan only covers services if rendered by network **providers**. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Preferred and Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% co-ins	Not Covered	None
	Specialist visit	10% co-ins	Not Covered	None
	Other practitioner office visit	10% co-ins for Manipulative (Chiropractic) Services	Not Covered	Limited to 20 visits of Manipulative (Chiropractic) Treatment per policy period. Pre-Authorization required or benefit reduces to 50% of allowed.
	Preventive care/screening/immunizati-on	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% co-ins	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Preferred and Non-Network Provider	
If you need drugs to treat your illness or condition. More information about drug coverage is at www.myuhc.com	Tier 1 - Your Lowest-Cost Option	Retail : $0 copay. Mail-Order: $90 copay.	Not Covered	Provider means pharmacy for purposes of this section. Retail : Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail : $25 copay. Mail-Order: $62.50 copay.	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail : $45 copay. Mail-Order: $112.50 copay.	Not Covered	
	Tier 4 - Additional High-Cost Options and Specialty Drugs	Not applicable	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins	Not Covered	None
	Physician/surgeon fees	10% co-ins	Not Covered	None
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	None
	Emergency medical transportation	10% co-ins	10% co-ins	None
	Urgent care	10% co-ins	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins	Not Covered	None
	Physician/surgeon fees	10% co-ins	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs.	Mental/behavioral health outpatient services	30% co-ins	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Preferred and Non-Network Provider	
	Mental/behavioral health inpatient services	10% co-ins	Not Covered	None
	Substance abuse disorder outpatient services	30% co-ins	Not Covered	None
	Substance abuse disorder inpatient services	10% co-ins	Not Covered	None
If you become pregnant	Prenatal and postnatal care	10% co-ins	Not Covered	Additional copays, deductibles, or co-ins may apply. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	10% co-ins	Not Covered	None
If you have a recovery or other special health need	Home health care	10% co-ins	Not Covered	Limited to 60 days per policy period.
	Rehabilitation services	10% co-ins	Not Covered	Depending on the type of therapy, there is a limit of 30 visits each per policy period.
	Habilitation services	10% co-ins	Not Covered	Habilitation Services may be covered for children up to age 19.
	Skilled nursing care	10% co-ins	Not Covered	Limited to 100 days per policy period.
	Durable medical equipment	10% co-ins	Not Covered	$2,500 max per policy period if device determined to be non-essential. Covers 1 per type of DME (including repair/replace) every 3 years.
	Hospice service	10% co-ins	Not Covered	
If your child needs dental or eye care	Eye exam	10% co-ins	Not Covered	1 exam every 2 years.
	Glasses	Not Covered	Not Covered	No Coverage for Glasses
	Dental check-up	Not Covered	Not Covered	No Coverage for Dental check-up

Excluded Services and Other Covered Services

Services Your Plan Does NOT cover (This isn't a complete list. Check your policy for others)			
• Cosmetic Surgery	• Dental care (Adult/Child)	• Glasses	• Long-term care
• Non-emergency care when travelling outside the U.S.	• Private-duty nursing	• Routine foot care	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services).			
• Acupuncture - may be covered with limitations	• Bariatric Surgery - may be covered with limitations	• Habilitation Services - may be covered with limitations	• Hearing aids - may be covered with limitations
• Infertility treatment - may be covered with limitations	• Routine eye care (adult) - may be covered with limitations		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or visit www.mdinsurance.state.md.us/sa. Additionally, a consumer assistance program can help you file your appeal. Contact Maryland Office of the Attorney General Health Education and Advocacy Unit at 1-877-261-8807 or TTY 1-800-576-6372 or visit www.oag.state.md.us/consumer.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.

若需要中文协助，请拨打您会员卡上的电话号码。

Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

_______________*To see examples of how this plan might cover costs for a sample medical situation, see the next page.* _______________

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5,310**
- **Patient pays $2,230**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Co-pays	$0
Co-insurance	$580
Limits or exclusions	$150
Total	**$2,230**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $3,770**
- **Patient pays $1,630**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Co-pays	$0
Co-insurance	$50
Limits or exclusions	$80
Total	**$1,630**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✱ **No** . Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✱ **No** . Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes** . When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes** . An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.