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.uhc.com/shopri** or by calling **1-877-856-2430.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$4,000** Indiv* **/ $8,000** Family Per calendar 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.	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?	Yes, Network: **$6,000** Indiv* **/ $12,000** 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't cover.	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 plan pays?	No.	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. For a list of **network providers**, see **www.uhc.com/shopri** or call **1-877-856-2430.**	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. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-877-856-2430** or visit us at **www.uhc.com/shopri.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** 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 Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit, after ded	$30 copay per visit, after ded	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit, after ded	$60 copay per visit, after ded	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$30 copay per visit, after ded	$30 copay per visit, after ded	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care / screening/im-munization	No Charge	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)	0% co-ins, after ded	0% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	0% co-ins, after ded	Not Covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.uhc.com/sho-pri.	Tier 1 - Your Lowest-Cost Option	Not Applicable	Retail: $20 copay, after ded Mail-Order: $50 copay, after ded Specialty Drugs: $20 copay, after ded	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-Authorization 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. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or co-ins may be applied.
	Tier 2 - Your Midrange-Cost Option	Not Applicable	Retail: $40 copay, after ded Mail-Order: $100 copay, after ded Specialty Drugs: $60 copay, after ded	Not Covered	
	Tier 3 - Your Highest-Cost Option	Not Applicable	Retail: $70 copay, after ded Mail-Order: $175 copay, after ded Specialty Drugs: $100 copay, after ded	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	0% co-ins, after ded	Not Covered	$250 outpatient surgery per occurrence copayment applies prior to the Annual Deductible.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	Not Covered	None
If you need immediate medical attention	Emergency room services	$250 copay per visit, after ded	$250 copay per visit, after ded	$250 copay per visit, after ded	Network Deductible applies.
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	0% co-ins, after ded	Network Deductible applies.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Urgent care	$75 copay per visit, after ded	$75 copay per visit, after ded	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	0% co-ins, after ded	Not Covered	$500 Inpatient Stay per occurrence copayment applies prior to the Annual Deductible.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay per visit, after ded	$60 copay per visit, after ded	Not Covered	None
	Mental/Behavioral health inpatient services	0% co-ins, after ded	0% co-ins, after ded	Not Covered	$500 Inpatient Stay per occurrence copayment applies prior to the Annual Deductible.
	Substance use disorder outpatient services	$60 copay per visit, after ded	$60 copay per visit, after ded	Not Covered	None
	Substance use disorder inpatient services	0% co-ins, after ded	0% co-ins, after ded	Not Covered	$500 Inpatient Stay per occurrence copayment applies prior to the Annual Deductible.
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	0% co-ins, after ded	0% co-ins, after ded	Not Covered	$500 Inpatient Stay per occurrence copayment applies prior to the Annual Deductible.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	0% co-ins, after ded	Not Covered	None
	Rehabilitation services	$30 copay per outpatient visit, after ded	$30 copay per outpatient visit, after ded	Not Covered	Limits per policy period: Physical, Occupational, Speech unlimited. Pulmonary 20 visits. Cardiac 36 visits.
	Habilitative services	$30 copay per outpatient visit, after ded	$30 copay per outpatient visit, after ded	Not Covered	Services provided under and limits are combined with Rehabilitation services above.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	0% co-ins, after ded	0% co-ins, after ded	Not Covered	None
	Durable medical equipment	0% co-ins, after ded	0% co-ins, after ded	Not Covered	None
	Hospice service	0% co-ins, after ded	0% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$30 copay per visit	$30 copay per visit	Not Covered	One exam every 12 months.
	Glasses	50% co-ins, after ded	50% co-ins, after ded	Not Covered	One pair every 12 months.
	Dental check-up	Not Covered	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

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 us at 1-877-856-2430; or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Rhode Island Department of Health at 401-222-5960 or www.health.ri.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-877-856-2430

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2430

如果需要中文的帮助，**请拨打这个号码** 1-877-856-2430

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-856-2430

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** $2,820
- **Patient pays** $4,720

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	$4,500
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$4,720**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $960
- **Patient pays** $4,440

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	$4,000
Copays	$400
Coinsurance	$0
Limits or exclusions	$40
Total	**$4,440**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

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