UnitedHealthcare
MAMSI Life and Health Insurance Co.

# UHC Choice EPO Gold 1000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: Based on group plan year**
**Coverage for:** Employee/Family | **Plan Type:** EPO

**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 **uhc.com/employer/small-business/shop/md** or by calling **1-877-856-2430.**

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$1,000** Indiv **/ $2,000** Family<br>Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge". | 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?** | Yes, prescription drugs - **$100** Indiv<br>There are no other specific **deductibles.** | You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out-of-pocket limit on my expenses?** | Yes, Network: **$4,000** Indiv **/ $8,000** Family | 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?** | Premiums, 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 **uhc.com/find-a-physician/shopmdoci** 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 **uhc.com** 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 Network Provider | Your Cost If You Use a Preferred and 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 | $25 copay per visit | Not Covered | Copay will only apply to member's assigned Primary Care Physician.<br>Virtual visits (Telehealth) - $25 copay per visit by a Designated Virtual Network Provider.<br>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Specialist visit | $50 copay per visit | Not Covered | Copay will only apply to Network with Referral.<br>If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. |
| | Other practitioner office visit | $25 copay per visit | Not Covered | Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. |
| | Preventive care/screening-/ immunization | 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) | Free Standing Provider: 20% co-ins, after ded<br>Hospital-Based: 20% co-ins, after ded | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | Free Standing Provider: No Charge<br>Hospital-Based: 20% co-ins, after ded | Not Covered | $250 Free Standing Provider per occurrence deductible applies prior to the Annual Deductible. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Preferred and Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at uhc.com/rxfind | Tier 1 - Your Lowest-Cost Option | Retail: $10 copay<br>Mail-Order: $25 copay<br>Specialty Drugs: $10 copay | Not Covered | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply.<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.<br>Certain drugs may have a Pre-Authorization requirement or may result in a higher cost.<br>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.<br>See the website listed for information on drugs covered by your plan. Not all drugs are covered.<br>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.<br>Tier 1 contraceptives are covered at No Charge. |
| | Tier 2 - Your Midrange-Cost Option | Retail: $40 copay<br>Mail-Order: $100 copay<br>Specialty Drugs: $100 copay | Not Covered | |
| | Tier 3 - Your Highest-Cost Option | Retail: $75 copay<br>Mail-Order: $187.50 copay<br>Specialty Drugs: $150 copay | Not Covered | |
| | Tier 4 (if applicable) - Additional High-Cost Options | Not Applicable | Not Applicable | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surg Center / Office: No Charge<br>Hospital-Based: 20% co-ins, after ded | Not Covered | $250 Ambulatory Surg Center/Office per occurrence deductible applies prior to the Annual Deductible. |
| | Physician/surgeon fees | 20% co-ins, after ded | Not Covered | None |
| **If you need immediate medical attention** | Emergency room services | 20% co-ins, after ded | 20% co-ins, after ded | Network Deductible applies. |
| | Emergency medical transportation | 20% co-ins, after ded | 20% co-ins, after ded | Network Deductible applies. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Preferred and Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Urgent care | $75 copay per visit | 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) | 20% co-ins, after ded | Not Covered | None |
| | Physician/surgeon fees | 20% co-ins, after ded | Not Covered | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $50 copay per visit | Not Covered | Partial hospitalization/intensive outpatient therapy: No Charge |
| | Mental/Behavioral health inpatient services | 20% co-ins, after ded | Not Covered | None |
| | Substance use disorder outpatient services | $50 copay per visit | Not Covered | Partial hospitalization/intensive outpatient therapy: No Charge |
| | Substance use disorder inpatient services | 20% co-ins, after ded | Not Covered | None |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | Not Covered | Additional copays, deductibles, or co-ins may apply depending on services rendered. |
| | Delivery and all inpatient services | 20% co-ins, after ded | Not Covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% co-ins, after ded | Not Covered | None |
| | Rehabilitation services | $25 copay per outpatient visit | Not Covered | Physical, Speech, Occupational limited to 30 visits per condition (each). Cardiac : 90 visits. |
| | Habilitative Services | $25 copay per outpatient visit | Not Covered | Age 18 and under: unlimited. Age 19 and older : services provided under and limits are combined with Rehabilitation services above. |
| | Skilled nursing care | 20% co-ins, after ded | Not Covered | Limited to 100 days per policy period. |
| | Durable medical equipment | 20% co-ins, after ded | Not Covered | None |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Preferred and Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Hospice service | 20% co-ins, after ded | Not Covered | None |
| **If your child needs dental or eye care** | Eye exam | $25 copay per visit | Not Covered | One exam every 12 months. |
| | Glasses | 50% co-ins | Not Covered | One pair every 12 months. |
| | Dental check-up | 0% co-ins, after ded | Not Covered | Cleanings covered 2 times per 12 months. Additional limitations may apply. |

## 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.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

## 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 the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Maryland Insurance Administration at 1-800-492-6116 or 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.

## 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-856-2430

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

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-856-2430

Navajo (Dine): 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.*

# UHC Choice EPO Gold 1000



## 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** $5,240
- **Patient pays** $2,300

### 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 | $1,000 |
| Copays | $0 |
| Coinsurance | $1,100 |
| Limits or exclusions | $200 |
| **Total** | **$2,300** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,660
- **Patient pays** $1,740

### 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 | $400 |
| Copays | $1,300 |
| Coinsurance | $0 |
| Limits or exclusions | $40 |
| **Total** | **$1,740** |

# 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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