UnitedHealthcare®

Benefit Summary

Choice HSA Silver 4500
Maryland - Choice
HSA - Plan BOWK

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Choice Plan with an HSA?

Use our national network and an HSA to save money.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network. You can save money when you use the health savings account (HSA) and the network.

> **Save money by staying in our network.** If you don't use the network, you'll have to pay for all of the costs.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

> **You can open a health savings account (HSA).** An HSA is a personal bank account to help you save and pay for your health care, and help you save on taxes.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choicehsa** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-insurance (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
20%	$4,500	20%

This Benefit Summary is to highlight your Benefits. Do not use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

MAMSI Life and Health Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Your cost if you use Network Benefits

Annual Deductible - Combined Medical and Pharmacy

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	$4,500 per year
Medical Deductible - Family	$9,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.

Out-of-Pocket Limit - Combined Medical and Pharmacy

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

Out-of-Pocket Limit - Individual	$6,700 per year
Out-of-Pocket Limit - Family	$13,400 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization. Service site review may be a component of the prior authorization process.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits
Acupuncture Services	
	20% co-insurance, after the medical deductible has been met.
Ambulance Services	
Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.
Non-Emergency Ambulance:	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Blood and Blood Products	
	20% co-insurance, after the medical deductible has been met.
Case Management Services	
	The amount you pay is based on where the covered health care service is provided.
Cellular and Gene Therapy	
Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Chiropractic Services	
Limited to 20 visits per condition per year.	20% co-insurance, after the medical deductible has been met.
Controlled Clinical Trials	
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Dental - Pediatric Services (Benefits covered up to age 19)	
Benefits provided by the National Options PPO 20 Network (INO-MAC).	
Dental - Pediatric Preventive Services	
Dental Prophylaxis (Cleanings) Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to eight per 12 months.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.
Space Maintainers (Spacers)	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Dental - Pediatric Diagnostic Services	
Evaluations (Check-up Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing, after the medical deductible has been met.
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing, after the medical deductible has been met.
Dental - Pediatric Basic Dental Services	
Endodontics (Root Canal Therapy)	20% co-insurance, after the medical deductible has been met.
Adjunctive Services Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General Anesthesia: Covered only when clinically Necessary. Occlusal Guard: Limited to one guard every 12 months.	20% co-insurance, after the medical deductible has been met.
Oral Surgery	20% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to one every 36 months per surgical area. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to two times per 12 months.	20% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite)	20% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	20% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Dental - Pediatric Major Restorative Services	
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Medically Necessary Orthodontics	
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for orthodontic treatment.
Dental Services - Accident Only	
	20% co-insurance, after the medical deductible has been met.
Dental Services - Hospital and Ambulatory Facility Charges Related to Dental Care	
Inpatient:	20% co-insurance, after the medical deductible has been met.
Outpatient:	20% co-insurance, after the medical deductible has been met.
Detoxification Services	
Inpatient:	20% co-insurance, after the medical deductible has been met.
Outpatient:	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided. Diabetes test strips are not subject to Co-insurance or Co-payment.
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and Prescription Drug Products. Diabetes test strips are not subject to Co-insurance or Co-payment.
Durable Medical Equipment (DME), Orthotics and Supplies	
	20% co-insurance, after the medical deductible has been met.
Emergency Health Care Services - Outpatient	
	20% co-insurance, after the medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.
Family Planning Services	
	20% co-insurance for a primary care physician office visit, after the medical deductible has been met. 20% co-insurance for a specialist office visit, after the medical deductible has been met. See Prescription Drug Products for cost sharing for contraceptive Prescription Drug Products.
Gender Dysphoria	
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Habilitative Services	
Inpatient:	The amount you pay is based on where the covered health care service is provided.
Outpatient: Outpatient therapies are limited per year as follows: Unlimited for Covered Persons up to age 19. For Covered Persons age 19 or older, limited to: 30 visits of physical therapy per condition. 30 visits of occupational therapy per condition. 30 visits of speech therapy per condition.	20% co-insurance, after the medical deductible has been met.
Hearing Aids	
Limited to one hearing aid per hearing impaired ear every 3 years.	20% co-insurance, after the medical deductible has been met.
Home Health Care	
Note: Home Health Care visits that are provided according to the benefit described in Section 1 of the COC are not subject to the Annual Deductible or Co-insurance. For the administration of intravenous infusion, you must receive services from a provider we identify.	20% co-insurance, after the medical deductible has been met.
Hospice Care	
	20% co-insurance, after the medical deductible has been met.
Hospital - Inpatient Stay	
	20% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Infertility Services	
	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient	
Lab Testing - Outpatient:	20% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	20% co-insurance, after the medical deductible has been met.
Lymphodema Services	
	The amount you pay is based on where the covered health care service is provided.
Major Diagnostic and Imaging - Outpatient	
	20% co-insurance, after the medical deductible has been met.
Medical Foods	
	20% co-insurance, after the medical deductible has been met.
Mental Health Care and Substance - Related and Addictive Disorders Services	
Inpatient:	20% co-insurance, after the medical deductible has been met.
Outpatient:	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.
Nutritional Services and Medical Nutrition Therapy	
	20% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, however you will never pay more than $150 per 30 day supply for a Specialty Prescription Drug Product, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services	
	20% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits
Physician's Office Services - Sickness and Injury	
	20% co-insurance for a primary care physician office visit, after the medical deductible has been met. 20% co-insurance for a specialist office visit, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.	
Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.	
Prosthetic Devices	
	20% co-insurance, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health care service is provided.

Covered Health Care Services	Your cost if you use Network Benefits
Rehabilitation Services - Outpatient Therapy	
Limited per year as follows: 90 visits of cardiac rehabilitation per therapy (physical, speech, occupational). 30 visits of physical therapy per condition. 30 visits of occupational therapy per condition. 30 visits of speech therapy per condition. One program per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy for pulmonary rehabilitation therapy.	20% co-insurance, after the medical deductible has been met.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 100 days per year when admitted to a Skilled Nursing Facility.	20% co-insurance, after the medical deductible has been met.
Surgery - Outpatient	
	20% co-insurance, after the medical deductible has been met.
Surgical Morbid Obesity Treatment	
For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Telehealth Services	
	The amount you pay is based on where the covered health care service is provided.

Covered Health Care Services	Your cost if you use Network Benefits
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.
Transplantation Services	
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Urgent Care Center Services	
	20% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.	
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	20% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Routine Vision Exam Limited to once per year.	20% co-insurance. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	50% co-insurance, after the medical deductible has been met.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing, after the medical deductible has been met.
Eyeglass Frames Limited to once every 12 months.	
Eyeglass frames with a retail cost up to $130.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $130 - 160.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $160 - 200.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $200 - 250.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than $250.	50% co-insurance, after the medical deductible has been met.
Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	50% co-insurance, after the medical deductible has been met.
Low Vision Care Services Limited to comprehensive low vision exam once every 5 years, including 4 follow-up visits in any 5-year period and prescribed optical devices, such as high-powered spectacles, magnifiers and telescopes.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- 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

MAMSI Life and Health Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug Products

Maryland Plan 816

Standard Drugs: 10/40/75 Specialty Drugs: 10/120/150

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on **myuhc.com®** or calling the Customer Care number on your ID card.

Annual Deductible	
Individual Deductible	See Medical Benefit Summary
Family Deductible	See Medical Benefit Summary

Out-of-Pocket Limit	
Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

A deductible and out-of-pocket limit may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket limit amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your co-payment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the co-payments outlined below. If you reach the out-of-pocket limit, you will not be required to pay a co-payment.

MAMSI Life and Health Insurance Company

Tier Level	Up to 31-day supply		Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	**Retail Non-Preferred Specialty Network Pharmacy**	***Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy**
Tier 1 Prescription Drug Products	**$10**	**Not Applicable**	**$20**
Tier 1 Specialty Prescription Drug Products	**$10**	**$20**	**Not Covered****
Tier 2 Prescription Drug Products	**$40**	**Not Applicable**	**$80**
Tier 2 Specialty Prescription Drug Products	**$120**	**$240**	**Not Covered****
Tier 3 Prescription Drug Products	**$75**	**Not Applicable**	**$150**
Tier 3 Specialty Prescription Drug Products	**$150**	**$300**	**Not Covered****

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

For Specialty Drugs from a Non-Preferred Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.

** Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. When you choose the higher cost drug of the two, you will pay the difference between the higher cost drug and the lower cost drug in addition to your Co-payment and/or Co-insurance that applies to the lower cost drug. The Ancillary Charge may not apply to any Out of Pocket Limit.

Other Important Information about your Outpatient Prescription Drug Benefits

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com® or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at myuhc.com® or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid. If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefits will be paid for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you may be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at myuhc.com® or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Certain PPACA Zero Cost Share Preventive Care Medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, or Annual Drug Deductible) as required by applicable law. You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at myuhc.com® or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com® or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

PHARMACY EXCLUSIONS

The following exclusions apply. In addition see your Certificate and SBN for additional exclusions and limitations that may apply.

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used for cosmetic purposes.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) in order to comply with essential health benefits requirements.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

MAMSI Life and Health Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jiik'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jiik'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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