Benefit Summary Select

Montgomery County Government Medical Plan

United HealthCare Services, Inc. and Montgomery County Government want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24 hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your health plan ID card.
- **Advocate telephone support** – Need more help? Call a Advocate using the toll-free number on the back of your health plan ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD 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.

Information on Pre-service Notification

**Pre-service Notification is required for certain services.*

Information on Benefit and Benefit Limits

- The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.
- All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description.
- When Benefit limits apply, the limit refers to Network Benefits unless specifically stated in the Benefit category.

Types of Coverage	Network Benefits
Deductibles and Co-insurance	
Individual Deductible	No Deductible
Family Deductible	No Deductible
Individual Out-of-Pocket Maximum	$1,100 per year
Family Out-of-Pocket Maximum	$3,600 per year
Lifetime Maximum Benefit • There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	No Lifetime Maximum Benefit
Physician Services and Preventive Care	
Primary Physician Office Visit – Sickness and Injury and Virtual Visits	100% after you pay a $5 Co-payment per visit
Specialist Physician Office Visit – Sickness and Injury	100% after you pay a $10 Co-payment per visit
Preventive Care Services Covered Health Services include but are not limited to:	
• **Primary Physician Office Visit**	$5 Co-payment per visit
• **Specialist Physician Office Visit**	$10 Co-payment per visit
• **Lab, X-Ray or Other Preventive Tests**	100% of Eligible Expenses
Hospital and Surgical Care	
Hospital – Inpatient Stay	100% of Eligible Expenses
Physician Fees for Surgical and Medical Services	100% of Eligible Expenses
Surgery – Outpatient	$25 Co-payment

Types of Coverage	Network Benefits
Outpatient Diagnostic Services	
Lab, X-Ray and Diagnostics – Outpatient	100% of Eligible Expenses
Lab, X-Ray and Major Diagnostics – Outpatient • Includes CT, PET, MRI, MRA and Nuclear Medicine	100% of Eligible Expenses
Scopic Procedures – Outpatient Diagnostic and Therapeutic • Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy and Endoscopy • For Preventive Scopic Procedures, refer to the Preventive Care Services category	100% of Eligible Expenses
Emergency and Medical Care	
Ambulance Services Emergency and Non-Emergency	100% of Eligible Expenses
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Co-payment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	100% after you pay a $25 Co-payment per visit
Urgent Care Center Services	100% after you pay a $15 Co-payment per visit
Other Services	
Acupuncture Benefits are limited to 12 visits per calendar year	100% after you pay a $10 Co-payment per visit
Chiropractic Treatment Benefits are limited to 24 visits per calendar year	50% of Eligible Expenses
Dental Services – Accident Only	100% of Eligible Expenses
Durable Medical Equipment (DME)[3] Benefits are limited as follows: • Benefits are unlimited for Durable Medical Equipment • Prior notification is required for items more than $1,000	50% of Eligible Expenses
Hearing Aids Benefits are limited as follows: • Children under age 19 are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	50% of Eligible Expenses
Home Health Care Benefits are limited as follows: • 60 visits per year	100% of Eligible Expenses
Hospice Care	100% of Eligible Expenses
Mental Health and Substance Use Services – Inpatient and Intermediate	100% of Eligible Expenses
Mental Health and Substance Use Services – Outpatient	$5 co-payment per visit
Pharmaceutical Products – Outpatient • This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	$5 Co-payment per visit for Medication management office visit
Pregnancy – Maternity Services For services provided in the Physician's Office, a Co-payment will only apply to the initial office visit.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.
Prosthetic Devices[3] Benefits are limited as follows: • Unlimited per calendar year. Benefits are limited to $350 per lifetime for a single hair prosthesis resulting from chemotherapy or radiation treatment for cancer when prescribed by a resident oncologist	50% of Eligible Expenses
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.
Rehabilitation Services – Outpatient Therapy Benefits are limited as follows: • 60 combined visits of physical therapy, occupational therapy, and speech therapy per calendar year	100% after you pay a $10 Co-payment per visit
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services Benefits are limited as follows: • 60 days per calendar year	100% of Eligible Expenses
Pharmacy Benefits for Diabetic Supplies Only Mail Order – One (1) Co-payment per 31-day consecutive supply for retail drugs and two and a half (2.5) Co-payments per 90-day supply for mail order drugs.	Tier 1 - $5 Co-payment per 31-day consecutive supply Tier 2 - $20 Co-payment per 31-day consecutive supply

Cost-sharing of co-pays for Network Mental Health & Substance Abuse Outpatient Professional Services will accumulate to the out-of-pocket maximum.