OPTIMUM CHOICE, INC.℠

A UnitedHealthcare® Company

Health Maintenance Organization (HMO) Plan
VA04TE0*ZO00

The Optimum Choice, Inc. HMO plan provides you with medical coverage through a network of participating physicians and other health care practitioners. To access specialty services, you will need a referral from your Primary Care Physician (PCP). PCPs usually specialize in family or general practice, internal medicine, obstetrics/gynecology (OB/GYN) or pediatrics. Each of your family members may choose a different PCP, and you can change your PCP as often as monthly.

Most of your medical care must be arranged and coordinated by your PCP. Your PCP will provide:

- Office visits when you are ill
- Preventive health care
- Immunizations for children and adults
- Health care education

Your PCP is also responsible for:

- Writing referrals for specialty care
- Arranging for hospitalizations
- Approving urgent care
- Arranging for behavioral health and substance abuse care
- Arranging for laboratory and X-ray services
- Arranging for outpatient services and surgery

There are usually no claim forms to fill out when you receive services from participating providers in our network. In some cases, you may incur out-of-pocket expenses for a Covered Service, such as in a medical emergency. If this happens, contact our Member Services Department for further assistance.

Some of the Important Benefits of the HMO Plan:

- You have access to a network of participating providers, including hospitals and specialists. Look on our Web site, www.mamsiUnitedHealthcare.com, to see our network of participating providers.
- Benefits include coverage for office visits and hospital care, including inpatient and outpatient surgery.
- Preventive services are covered including:
    - Childhood immunizations
    - Well-woman services (e.g., pap smears, mammograms)
- Prenatal care
- Routine check-ups
- Vision and hearing screening

Corporate Headquarters:
4 Taft Court
Rockville, MD 20850
www.mamsiUnitedHealthcare.com

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Health Benefits Summary

Important Information

- This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. This Plan may not cover all of your health care expenses. **More complete descriptions of your benefits and the terms under which your benefits are provided are contained in the Evidence of Coverage (EOC) that you will receive upon enrolling in the Plan.**
- If this Benefit Summary conflicts in any way with your EOC, the EOC shall prevail.
- Terms that are capitalized in the Benefit Summary are defined in your EOC.
- Benefits are payable for Covered Services (except emergency services) coordinated and/or arranged by your Primary Care Physician.
- All exclusions and limitations applicable to this Plan are described in your EOC, and any riders and endorsements.
- **Annual Deductible:** $500 per Member
- **Out-of-Pocket Maximum:** $1,800 Single,$3,600 Employee/Spouse,$3,600Employee/Child, $5,900 Family. Copayment for some Covered Services may not apply to the Out-of-Pocket Maximum as specified in the EOC.

Types of Coverage

HMO Benefits:	You Pay:
1. **Acupuncture**	$30.00 Copayment up to 12 Visits per Member per Contract Year and covered only for postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, postoperative dental pain and as part of a comprehensive treatment program for chronic pain.
2. **Chiropractic Visits**	50% Copayment of the Charges up to $500 per Member per Contract Year.
3. **Circumcision**	Covered in Full.
4. **Diagnostic Lab Tests**	Applicable Copayment. Not Subject to Annual Deductible if services received in Office Setting.
5. **Emergency Room Visits**	$100.00 Copayment for services that meet the Plan's definition of Emergency Services. Copayment is waived if the Member is admitted to the Hospital in which case the Inpatient Hospital Copayment applies. Services that do not meet the Plan's definition of Emergency Services are not covered.
6. **Eye Refraction Exam**	$25.00 Copayment-No referral Necessary when seeking care from a Participating Provider.
7. **Hospital-Inpatient Stay**	$200.00 Copayment per day up to a $1,000 maximum per Admission. Requires Preadmission Authorization.
8. **Infertility Treatment**	Not a Covered Service.
9. **Initial Allergy Consultation**	$30.00 Copayment
10. **Maternity Care**	$30.00 Copayment; all other non-office visit Copayment apply.
11. **Mental Health Care/Substance Abuse-Inpatient**	$50.00 Copayment per day up to 30 combined days per Member per Contract Year. For Inpatient Substance Abuse, the plan pays the first $80.00 per day; the Member is responsible for next $50.00 per day. The Plan pays the remaining Charges in excess of $130 per day up to 30 days

HMO Benefits:	You Pay:
	which count toward the total Mental Health maximum per Member per Contract Year. (There is a 90 day lifetime limit for Rehabilitation). Requires Preadmission Authorization.
12. Mental Health Care/Substance Abuse-Outpatient	50% Copayment of Charges per visit up to 20 visits per Member per Contract Year.
13. OB/GYN Office Visits	$30.00 Copayment - For Female Members age 13 and older, an annual examination and routine health care services incident to and rendered during the annual visit to a participating OB/GYN or participating Certified Nurse Midwife are covered without referral; this includes follow-up care or subsequent visits. No Copayment required for participating Certified Nurse Midwife services.
14. Outpatient Hospital Services	$30.00 Copayment.
15. Outpatient Hospital Surgeries	$200.00 Copayment.
16. Primary Care Physician Office Visit	$20.00 Copayment.
17. Routine Physical Exams	$20.00 Copayment for Covered Services.
18. Skilled Nursing Facility	Covered in Full up to 60 days per Member per Contract Year. Requires Preadmission Authorization.
19. Specialist Office Visits	$30.00 Copayment.
20. Speech, Occupational and Physical Therapy	$30.00 Copayment up to 60 visits/90 days per Condition, whichever is greater. Not Subject to Annual Deductible if Services received in office setting.
21. Urgent Care Facility Visits	$30.00 Copayment.
22. Well Child Care	$20.00 Copayment for Covered Services.
23. X-rays	Applicable Copayment. Not Subject to Annual Deductible if services received in Office Setting.

Additional Benefits:	You Pay:
Ambulance Service	Covered in Full when Medically Necessary.
Bilateral Vasectomy Services	$30.00 Copayment.
Biologically Based Mental Illness/Substance Abuse-Inpatient	Same Copayment as Inpatient Hospital Services. Requires Preadmission Authorization.
Biologically Based Mental Illness/Substance Abuse-Outpatient	Same Copayment as Outpatient Hospital Services; Applicable Copayment for Office Visit.
Durable Medical Equipment	50% Copayment of Charges. Requires Prior Authorization.
Home Health Care	Covered in Full.
Hospice Services	Applicable Copayment.
Mammography Examinations	Services provided by a Hospital are subject to the Specialist Copayment and are subject to the Annual Deductible. Services provided in an Office Setting are subject to a Specialist Copayment but are not subject to the Annual Deductible.

Plan offered by: Optimum Choice, Inc.
4 Taft Court.·
Rockville, MD 20850
www.mamsiUnitedHealthcare.com

Rider Package: VA04TE0*ZO00 (TE*ZO)
EOC Form Number: 0401261-0104VA

Additional Benefits:	You Pay:
Medication Management office visits associated with Mental Health or Substance Abuse	Services subject to Copayment stated under Outpatient Mental Health/Substance Abuse.
Norplant Services	$30.00 Copayment.
Orthopedic Braces	50% Copayment of Charges. Requires Prior Authorization.
Partial Hospitalization Mental Health and Substance Abuse	Services subject to Copayment and limit stated under Outpatient Mental Health/Substance Abuse.
Transplants	All non-experimental solid organ and bone marrow transplants are covered when deemed to be Medically Necessary. In order to be a covered benefit, a transplant must be considered non-experimental as of the last Effective Date of the Group Agreement, which is either the initial Effective Date or the renewal Effective Date. Subject to Applicable Copayment. Requires Preadmission Authorization.
Tubal Ligation Services	$200.00 Copayment.

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Pharmacy Benefits Summary

Types of Coverage

Prescription Drugs:	You Pay:
1. **Tier 1**	$10.00 Copayment
2. **Tier 2**	$20.00 Copayment
3. **Tier 3**	$35.00 Copayment
4. **Injectables**	With the exception of insulin and injectable contraceptive drugs, there is a 20% Copayment of pharmacy contract rate up to $50.00 for injectables.
5. **Mail Order**	One (1) Copayment per 31 day consecutive supply for retail drugs and two (2) Copayments per 90 day supply for mail order drugs. Oral contraceptives at three (3) Copayments for three-cycle supply for retail purchase and two (2) Copayments for three-cycle supply for mail order purchases.
6. **Ancillary**	Member must pay the difference between the cost of a Tier 3 or Tier 2 medication and a Tier 1 equivalent after payment of the appropriate Copayment. However, the Member will never pay more than the cost of the drug.
7. **Deductibles**	No Annual Deductible

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Pharmacy Rider Package: ZO
Prescription Drug Rider Form Number: 0443135-0205VA

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