OPTIMUM CHOICE, INC.℠

A UnitedHealthcare® Company

Health Maintenance Organization (HMO) Plan
VA042DI*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

OPTIMUM CHOICE, INC.℠

A UnitedHealthcare® Company

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:** No Deductible
- **Out-of-Pocket Maximum:** $1,000 Single, $1,900 Employee/Spouse, $1,700 Employee/Child $3,100 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**	$25.00 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. The Specialist Copayment will apply for covered Outpatient Diagnostic Lab Tests, and covered Outpatient X-rays performed at a Participating Hospital Service Center. This does not include services related to Infertility. Hospital Service Center means a select number of Hospitals that perform Outpatient Diagnostic Lab Tests, and Outpatient X-Rays.
5. **Emergency Room Visits**	$50.00 Copayment for services related to Conditions that meet the Plan definition of a Medical Emergency. Copayment is waived if admitted to the Hospital, in which case the Inpatient Hospital Copayment applies. Services related to Conditions that do not meet the Plan definition of a Medical Emergency are not covered.
6. **Eye Refraction Exam**	$25.00 Copayment-No referral necessary when seeking care from a Participating Provider
7. **Hospital-Inpatient Stay**	$300.00 Copayment per Admission. Requires Preadmission Authorization
8. **Infertility Treatment**	50% Copayment of Charges for Covered Services

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

Rider Package: VA042DI*--00
EOC Form Number: 0401204-0100VA

HMO Benefits:	You Pay:
9. Initial Allergy Consultation	$25.00 Copayment
10. Maternity Care	$25.00 Copayment; all other non-office visit Copayment are applicable
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 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	$25.00 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 or Surgery Visits	$50.00 Copayment
15. Primary Care Physician Office Visit	$15.00 Copayment
16. Routine Physical Exams	$15.00 Copayment for Covered Services
17. Skilled Nursing Facility	$300.00 Copayment per Admission up to 60 days per Member per Contract Year. Requires Preadmission Authorization
18. Specialist Office Visits	$25.00 Copayment
19. Speech, Occupational and Physical Therapy	$25.00 Copayment up to 60 visits or 90 days per Member per Contract Year, whichever is greater. There is a $5,000 limit for Early Intervention Services per Member per Contract Year
20. Urgent Care Facility Visits	$25.00 Copayment
21. Well Child Care	$15.00 Copayment for Covered Services
22. X-rays	Applicable Copayment. The Specialist Copayment will apply for covered Outpatient Diagnostic Lab Tests, and covered Outpatient X-rays performed at a Participating Hospital Service Center. This does not include services related to Infertility. Hospital Service Center means a select number of Hospital that perform Outpatient Diagnostic Lab Tests, and Outpatient X-Rays.

Additional Benefits:	You Pay:
Ambulance Service	Covered in Full when Medically Necessary
Bilateral Vasectomy Services	$25.00 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

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

Rider Package: VA042DI*--00
EOC Form Number: 0401204-0100VA

Additional Benefits:	You Pay:
Durable Medical Equipment	50% Copayment of Charges. Requires Prior Authorization
Home Health Care	Covered in Full
Hospice Services	Covered in Full. Requires Preadmission Authorization
Mammography Examinations	Applicable Copayment.
Medication Management office visits associated with Mental Health or Substance Abuse	Services subject to Copayment stated under Outpatient Mental Health/Substance Abuse
Norplant Services	50% Copayment of Charges
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	Heart, heart/lung, lung, liver, pancreas, kidney, cornea, and all non-experimental bone marrow transplants are covered when deemed Medically Necessary by the Plan. Subject to Applicable Copayment
Tubal Ligation Services	$50.00 Copayment

OPTIMUM CHOICE, INC.℠

A UnitedHealthcare® Company

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

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

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

05/20/05 LL