

OPTIMUM  
CHOICE, INC.<sup>SM</sup>  
A UnitedHealthcare<sup>®</sup> Company

**Direct Access Plan  
(MD042bD\*KI00)**

The Optimum Choice, Inc. Direct Access Plan provides you with medical coverage through a network of preferred physicians and other health care practitioners. No referrals are needed.

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 Direct Access Plan:***

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- You have access to a network of participating providers, including hospitals and specialists. Look on our Web site, [www.mamsiUnitedHealthcare.com](http://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](http://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.
- All exclusions and limitations applicable to this Plan are described in your EOC.
- **Out-of-Pocket Maximum:** Copayments for some Covered Services may not apply to the Out-of-Pocket Maximum as specified in the Group Certificate See grid below.

	Out-of-Pocket Maximum For 2 Tier Rate Structure	Out-of-Pocket Maximum For 3 Tier Rate Structure	Out-of-Pocket Maximum For 4 Tier Rate Structure	Out-of-Pocket Maximum For 5 Tier Rate Structure
Single	\$1,100	\$1,100	\$1,100	\$1,100
Employee/Spouse	\$3,200	\$2,200	\$2,200	\$2,200
Employee/Child	\$3,200	\$3,600	\$1,900	\$2,200
Family	\$3,200	\$3,600	\$3,600	\$3,600
Employee/Children	\$3,200	\$3,600	\$3,600	\$2,600

### 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 Charges up to \$500.00 per Member per Contract Year.
3. Circumcision	Covered In Full.
4. Covered Transplants	Heart, heart/lung, lung, liver, pancreas, kidney, cornea and all non-experimental bone marrow transplants when deemed Medically Necessary. Requires Preadmission Authorization & Precertification. Member must meet certain criteria. Subject to Applicable Copayment/Deductible.

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Rockville, MD 20850

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Rider Package: MD042bD\*KI00 (7B\*KI + 38.1868 + 38.1929 + 38.2224 + 38.918)

EOC Form Number: 0401154-0498MD

<b>HMO Benefits:</b>	<b>You Pay:</b>
5. <b>Diagnostic Lab Tests</b>	Applicable Copayment
6. <b>Emergency Room Visits(no referral necessary)</b>	\$75.00 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 Applicable Inpatient Hospital Copayment and/or Deductible apply. Services that do not meet the Plan's definition of Emergency Services are not covered.
7. <b>Eye Refraction Examination (no referral necessary)</b>	\$25.00 Copayment
8. <b>Hospital- Inpatient Stay</b>	Covered In Full. Requires Preadmission Authorization.
9. <b>Maternity Care</b>	\$30.00 Copayment; all other non-office visits Copayments apply.
10. <b>Medication management office visit associated with mental health or substance abuse</b>	\$30.00 Copayment
11. <b>Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse– Inpatient –</b>	Covered In Full. Requires Preadmission Authorization.
12. <b>Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse – Outpatient</b>	20% Copayment of Charges per visit 1-5; 35% Copayment of Charges per visit for visits 6-30; 50% Copayment of Charges per visit thereafter.
13. <b>OB/GYN Office Visits (no referral necessary)</b>	\$20.00 Copayment
14. <b>Occupational, and Physical Therapy Visits</b>	\$30.00 Copayment up to 60 visits per incident or injury. These limits are combined with the limits stated under Speech Therapy.
15. <b>Outpatient Hospital Services</b>	\$30.00 Copayment
16. <b>Outpatient Hospital Surgery</b>	\$50.00 Copayment
17. <b>Partial Hospitalization Mental health/Substance abuse</b>	\$30.00 Copayment up to 60 days per Member per Contract Year.
18. <b>Primary Care Physician Office Visits</b>	\$20.00 Copayment- Primary Care Services are those services rendered by a Health Care Practitioner in the following disciplines: General Internal Medicine, Family Practice, Pediatrics, or Obstetrics/Gynecology.
19. <b>Routine Physical Exam</b>	\$20.00 Copayment for covered services.
20. <b>Skilled Nursing Facility</b>	Covered In Full up to 60 days per Member per Contract Year. Requires Preadmission Authorization.
21. <b>Specialist Office Visits</b>	\$30.00 Copayment
22. <b>Speech Therapy</b>	\$30.00 Copayment up to 60 visits per Condition. These limits are combined with the limits stated under Occupational and Physical Therapy. Visit limit does not apply to the treatment of cleft lip/cleft palate or both.
23. <b>Urgent Care Facility Visits</b>	\$35.00 Copayment
24. <b>Well Child Care</b>	\$20.00 Copayment for covered services.
25. <b>X-rays</b>	Applicable Copayment

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<b>Additional Benefits:</b>	<b>You Pay:</b>
Ambulance Service	Covered In Full when Medically Necessary. Requires Preauthorization.
Bilateral Vasectomy Services	\$30.00 Copayment
Durable Medical Equipment	50% Copayment of Charges. Requires Prior Authorization.
Habilitative Services for Children under Age 19	\$30.00 Copayment for Occupational, Physical and Speech Therapy for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the child's ability to function (coverage not provided if services are delivered through Early Intervention or School Services).
Hair Prosthesis	50% Copayment of Charges – One Hair Prosthesis will be covered for a Member whose hair loss results from chemotherapy or radiation treatment for cancer when prescribed by the Oncologist in attendance (the cost shall not exceed \$350.00 and coverage is limited to one hair prosthesis per lifetime). Requires Prior Authorization.
Hearing Aid for Children under 19	50% Copayment of Charges up to \$1,400 per hearing aid for each hearing-impaired ear every 36 months if hearing aid is prescribed, fitted, and dispensed by a licensed audiologist. Requires Prior Authorization.
Home Health Care	Covered In Full.
Hospice Care	Covered In Full. Requires Preadmission Authorization.
Infertility Treatment – Artificial Insemination	50% Copayment of Charges (limited to 6 cycles per lifetime).
Infertility Services – In Vitro Fertilization	50% Copayment of Charges (limited to 3 attempts per live birth, not to exceed a maximum lifetime limit of \$100,000); the Member must meet certain criteria.
Initial Allergy Consultation	Applicable Copayment
Norplant Services	Applicable Copayment
Orthopedic Braces	50% Copayment of Charges. Requires Prior Authorization.
Tubal Ligation Services	\$50.00 Copayment

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## *Pharmacy Benefits Summary*

### Types of Coverage

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<b>Prescription Drugs:</b>	<b>You Pay:</b>
1. Tier 1	\$10.00 Copayment per 31-day supply
2. Tier 2	\$20.00 Copayment per 31-day supply
3. Tier 3	\$35.00 Copayment per 31-day supply
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 three (3) Copayments per 90 day supply for mail order drugs. Oral contraceptives at three (3) Copayments for three-cycle supply.

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Pharmacy Rider Package: KI  
Prescription Drug Rider Form Number: 0443147-1005MD