

# OPTIMUM CHOICE, INC. <sup>SM</sup>

A UnitedHealthcare<sup>®</sup> Company

## Health Maintenance Organization (HMO) Plan MD04S88\*FM00

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:***

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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.
- 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 Annual Deductible
- **Out-of-Pocket Maximum:** Copayments for some Covered Services may not apply to the Out-of-Pocket Maximum as specified in the EOC. 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	\$2,900	\$2,900	\$2,900	\$2,900
Employee/Spouse	\$8,800	\$5,500	\$5,500	\$5,500
Employee/Child	\$8,800	\$5,500	\$5,500	\$5,500
Family	\$8,800	\$8,800	\$8,800	\$8,800
Employee/Children	\$8,800	\$8,800	\$8,800	\$7,000

### Types of Coverage

HMO Benefits:	You Pay:
1. <b>Chiropractic Visits</b>	30% of Allowable Charges up to maximum of 20 visits per Condition per Member per Group Agreement Year
2. <b>Diagnostic Lab Tests</b>	\$40.00 Copayment or 50% of cost of the services, whichever is less
3. <b>Emergency Room Visits</b>	\$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 Hospitalization Copayment apply. Services that do not meet the Plan's definition of Emergency Services are not covered.
4. <b>Eye Refraction Exam</b>	\$30.00 Copayment for children through age 17. \$40.00 Copayment for adults 18 and older. No referral necessary for services obtained from a Participating Provider
5. <b>Hospital-Inpatient Stay</b>	Covered in Full – Physician Inpatient Visit Copayments Apply.
6. <b>Infertility Services</b>	50% Copayment of Charges for covered services.

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Rider Package: MD04S88\*--00  
EOC Form Number: 0401180-0799MD

<b>HMO Benefits:</b>	<b>You Pay:</b>
7. <b>Maternity care</b>	\$40.00 Copayment (All other non-office visit Copayment apply)
8. <b>Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse – Inpatient</b>	Covered in full for a maximum of 60 days per Member per Contract Year.
9. <b>Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse – Outpatient</b>	30% of Allowable Charges. A visit made solely for Medication Management purposes will not be counted as a visit for Mental Illness, Emotional Disorder, Drug Abuse or Alcohol Abuse
10. <b>OB/GYN Office Visits</b>	\$40.00 Copayment. Female Members may have direct access to a Participating OB/GYN or Participating Certified Nurse Midwife without a PCP referral for Medically Necessary OB/GYN care, including, but not limited to, routine care. If the Member requires the services of another Specialty Provider, the Member's PCP must determine the Necessity of a referral. No Copayment required for Participating Certified Nurse/Midwife services.
11. <b>Outpatient Hospital Services or Surgery Visits</b>	\$40.00 Copayment
12. <b>Primary Care Physician Office Visit</b>	\$30.00 Copayment
13. <b>Skilled Nursing Facility</b>	\$40.00 Copayment per day up to a maximum of 100 days per Member per Group Agreement Year.
14. <b>Specialist Office Visits</b>	\$40.00 Copayment
15. <b>Speech, Occupational and Physical Therapy</b>	30% of Allowable Charges up to a Maximum of 30 visits per Condition per Contract Year for Physical Therapy; Up to a Maximum of 30 visits per Condition per Contract Year for Speech Therapy; and Up to a Maximum of 30 visits per Condition per Contract Year for Occupational Therapy
16. <b>Urgent Care Facility Visits</b>	\$40.00 Copayment
17. <b>Well Child Visits for Children 0-2 years</b>	\$10.00 Copayment
18. <b>Well Child Visits for Children 2-13 years</b>	\$10.00 Copayment for visits that include Immunizations. Applicable Copayments apply to other Well Child Visits.
19. <b>X-rays</b>	\$40.00 Copayment or 50% of cost of the services, whichever is less

<b>Additional Benefits:</b>	<b>You Pay:</b>
<b>Ambulance Service</b>	Covered in Full when Medically Necessary
<b>Durable Medical Equipment</b>	\$40.00 Copayment when Medically Necessary. Requires Prior Authorization
<b>Habilitative Services for Children Under the Age of 19</b>	Applicable Copayment for children 0 through 19 years old for the treatment of Congenital or Genetic Birth Defects. Habilitative Services shall include services for cleft lip or cleft plate, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy and occupational therapy. Except for Habilitative Services provided in Early Intervention or School Services.
<b>Hearing Aid for Children Under the Age of 19</b>	\$40.00 Copayment for persons up to eighteen (18) years old, up to one thousand four hundred dollars (\$1,400) per hearing aid for each hearing-impaired ear every thirty six (36) months.
<b>Home Health Care</b>	Covered in full when Medically Necessary

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<b>Additional Benefits:</b>	<b>You Pay:</b>
<b>Mammography Examinations</b>	Medically Necessary Mammography Services are Covered in full after Applicable Copayments. Preventive Mammography Services for women 40-49 years of age are Covered in Full every other Calendar Year, and once every Calendar Year for women 50 and older, after Applicable Copayments.
<b>Medical Food for Treatment of Metabolic Disorders</b>	\$40.00 Copayment when Medically Necessary
<b>Medication Management Office Visits Associated with Mental Health/Substance Abuse</b>	\$40.00 Copayment
<b>Nutritional Services</b>	\$40.00 Copayment up to a Maximum of 6 visits per Condition per Member per Group Agreement Year
<b>Partial Hospitalization Mental Health and Substance Abuse</b>	\$40.00 Copayment
<b>Physician Inpatient Hospital Visit</b>	\$30.00 Copayment
<b>Transplants</b>	Covered in Full after applicable Copayment for heart, heart/lung, liver, lung, kidney, cornea, pancreas, pancreas/kidney, autologous and nonautologous bone marrow transplants. Requires Preadmission Authorization and Precertification.

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*Pharmacy Benefits Summary*

**Types of Coverage**

<b>Prescription Drugs:</b>	<b>You Pay:</b>
1. Tier 1	\$15.00 Copayment
2. Tier 2	\$25.00 Copayment
3. Tier 3	\$50.00 Copayment
4. 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. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment or the Home Delivery Pharmacy's Prescription Drug Cost.
5. Deductibles	No Annual Deductible

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Pharmacy Rider Package: FI  
Prescription Drug Rider Form Number: 044381-0701MD