

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

**Benefits Summary**  
**Point of Service (POS) Plan**  
**Base Plan**  
**MD04S90\*FNSA**

The Optimum Choice, Inc. POS plan provides you with medical coverage through a network of participating physicians or non-participating physicians and other healthcare practitioners. To access specialty services using your HMO benefits, you will need a referral from your Primary Care Physician (PCP). If you use your POS benefits, you do not need a referral to access specialty services through MAMSI Life and Health Insurance Company (MLH). 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.

***Some of the Important Benefits of the POS Plan:***

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- You have access to a network of participating providers, including hospitals and specialist. 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

Be sure to check your policy documents for more detail. Some services may only be available through your HMO benefits

Corporate Headquarters:  
4 Taft Court  
Rockville, MD 20850

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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 description of your Benefits and the terms under which your benefits are provided are contained in the Evidence of Coverage (EOC) and Group Certificate that you will receive upon enrolling in the Plan.**
- If this Benefit Summary conflicts in any way with your EOC or Group Certificate, the EOC or Group Certificate shall prevail.
- Terms that are capitalized in the Benefit Summary are defined in the EOC or Group Certificate.
- HMO Benefits are payable for Covered Services (except emergency services) coordinated and/or arranged by your Primary Care Physician (PCP). POS Benefits are payable for Covered Services (except emergency services) that are not coordinated and/or arranged by your PCP.
- All exclusions and limitations applicable to this Plan are described in your EOC or Group Certificate, and any riders and endorsements.
- **Annual Deductible:** HMO Benefits : No Deductible POS Benefits: \$500 Single, \$1,000 Family
- **Out-of-Pocket Maximum:** Copayments for some Covered Services may not apply to the Out-of-Pocket Maximum as specified in the EOC and Group Certificate. See grid below.

HMO Out-of-Pocket Maximum	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

POS Out-of-Pocket Maximum	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	\$3,400	\$3,400	\$3,400	\$3,400
Employee/Spouse	\$6,800	\$6,800	\$6,800	\$6,800
Employee/Child	\$6,800	\$6,800	\$6,800	\$6,800
Family	\$6,800	\$6,800	\$6,800	\$6,800
Employee/Children	\$6,800	\$6,800	\$6,800	\$6,800

\*Out-Of-Plan benefits are provided through MLH and do not require referral or coordination by your PCP. If you choose a Non -Preferred provider, the Plan is responsible for payment of the applicable percentage of either the requested Charges or the Allowable charges, whichever is less.

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Rider Package: MD04S90\*FNSA (SG2\*FN + 38.2447 +  
SG + 38.1548 + 38.2202)  
EOC Form Number: 0401180-0799MD  
Group Certificate Form Number: 0726161-0798MD

<b>Types of Coverage</b>	<b>HMO Benefits (You Pay)</b>	<b>*POS Benefits (Plan Pays)</b>
1. <b>Chiropractic Visits</b>	30% of Allowable Charges up to maximum of 20 visits per Condition per Member per Group Agreement Year	60% limited to 20 visits for Manual Manipulations of the Spine per Member per Condition per Contract Year.
2. <b>Diagnostic Lab Tests</b>	\$40.00 Copayment or 50% of cost of the services, whichever is less	80%
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 Hospital Copayment applies. Services that do not meet the Plan's definition of Emergency Services are not covered.	Services received in an Emergency Room that meet the Plan's definition of an Emergency are payable In-Plan
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	80%
5. <b>Hospital Inpatient Stay</b>	\$1,000 Copayment	80%
6. <b>Infertility Services</b>	50% Copayment of Charges for covered services.	40% for covered services.
7. <b>Maternity Care</b>	\$40.00 Copayment (All other non-office visit Copayments apply)	80% for Inpatient Physician and other services
8. <b>Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse – Inpatient</b>	\$1,000.00 Copayment for a maximum of 60 combined days, per Member per Agreement Year.	80% up to a maximum of 25 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	80% per visit for visits 1-5; 65% per visit for visits 6-30; 50% thereafter.
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	80%

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	required for Participating Certified Nurse Midwife Services.	
11. Outpatient Hospital Services or Surgery Visits	\$40.00 Copayment	80%
12. Primary Care Physician Office Visit	\$30.00 Copayment	80% Preventive and Well Child benefits are included.
13. Skilled Nursing Facility	\$40.00 Copayment per day.	80% maximum of 60 days per Member per Contract Year
14. Specialist Office Visits	\$40.00 Copayment.	80%
15. Speech, Occupational and Physical Therapy	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	60% for up to 30 visits for Speech, Occupational and Physical Therapy.
16. Urgent Care Facility Visits	\$40.00 Copayment	80%
17. Well Child Visits for Children 0-2 years	\$10.00 Copayment	80% for covered services. Not Subject to Annual Deductible
18. Well Child Visits for Children 2-13 years	\$10.00 Copayment for visits that include Immunizations. Applicable Copayments apply to other Well Child Visits.	80% for covered services. Not Subject to Annual Deductible
19. X-rays	\$40.00 Copayment or 50% of cost of the services, whichever is less	80%

<b>Additional Benefits:</b>	<b>HMO Benefits (You Pay)</b>	<b>*POS Benefits (Plan Pays)</b>
<b>Ambulance Service</b>	Covered in Full when Medically Necessary	80% when Medically Necessary
<b>Durable Medical Equipment</b>	\$40.00 Copayment when Medically Necessary. Requires Prior Authorization	80% Requires Precertification
<b>Habilitative Services for Children Under the Age of 19</b>	\$40.00 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	60% Same criteria as In-Plan Benefit

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	Intervention or School Services.	
<b>Hearing Aid for Children Under the Age of 19</b>	\$40.00 Copayment up to \$1,400 per Ear every 36 months if prescribed, fitted and dispensed by a participating licensed audiologist. Requires Prior Authorization.	80% for hearing aids 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.	80%
<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.	80% in accordance with the intervals set for in the Contract. Not Subject to Annual Deductible.
<b>Medical Food for Treatment of Metabolic Disorders</b>	\$40.00 Copayment when Medically Necessary	80%
<b>Medication Management Office Visits Associated with Mental Health/Substance Abuse</b>	\$40.00 Copayment	80%
<b>Nutritional Services</b>	\$40.00 Copayment up to a Maximum of 6 visits per Condition per Member per Group Agreement Year	80%
<b>Partial Hospitalization Mental Health and Substance Abuse</b>	\$40.00 Copayment	80%
<b>Physician Inpatient Hospital Visit</b>	\$30.00 Copayment	80%
<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.	80% Same criteria as In-Plan benefits. Requires Preadmission Authorization and Precertification

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*Pharmacy Benefits Summary  
Point-of-Service (POS) Plan*

**Types of Coverage**

Prescription Drugs	HMO Benefits	POS Benefits
<b>1. Deductible</b>	Member meets a \$2,500 Deductible if Member has individual coverage, or a \$5,000 Deductible if Member has family coverage. Once Deductible is met, Member pays a 75% Coinsurance for Prescription Drugs.	Same as Preferred Provider Option

Note: POS benefits are provided by MAMSI Life and Health Insurance Company.

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Pharmacy Rider Package: FN  
Prescription Drug Rider Form Number: 04382699-0706MD