OPTIMUM CHOICE, Inc. Preferred *Plan KXG*

A UnitedHealthcare Company

The Optimum Choice, Inc. Preferred plan provides you with medical coverage through a network of participating or non-participating providers, including hospitals and specialists.

With this plan, you will receive the highest level of benefits when you seek care from your Primary Care Physician (PCP). To access specialty services, you will need a referral from your Primary Care Physician (PCP). PCP's 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. If you use your Point-of-Service benefits, you do not need a referral to access specialty services through MAMSI Life and Health Insurance Company (MLH).

We will provide benefits for Emergency Health Services even if you do not have a referral from your Primary Care Physician. Whenever possible, you should contact your Primary Care Physician before receiving Emergency Health Services, and then seek care from the Network provider designated.

You also may choose to seek care outside the Network, without a referral. There are two levels of Non-Network Benefit. Preferred Non-Network Benefits apply when you receive care from a Network provider without a referral from your PCP. Non-Preferred Non-Network Benefits apply when you receive care from a Non-Network provider. However, you should know that care received from a non-network physician, facility, or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside of the Network, MLH only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to your Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional for information about their billed charges *before you receive care*.

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

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities, and other health care professionals, including specialists.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Preventive health care including: childhood immunizations, mammograms, vision and hearing screenings.

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 Customer Service for further assistance.

Optimum Choice, Inc. Preferred *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Preferred and Non-Preferred Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. * Pre-admission authorization is required for these services.	**Annual Deductible:** $500 per Covered Person per policy year, not to exceed $1,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $2,500 per Covered Person, per policy year, not to exceed $5,000 for all Covered Persons in a family. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** No Maximum Policy Benefit	**Annual Deductible:** $1,000 per Covered Person per policy year, not to exceed $2,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $4,500 per Covered Person, per policy year, not to exceed $9,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** No Maximum Policy Benefit
1. Acupuncture Services Any combination of Network, Preferred and Non-Preferred Non-Network Benefits are limited to 12 visits per Policy year.	$50 per visit	50% of Eligible Expenses
2. Ambulance Services Benefits are provided for Medically Necessary non-Emergency ambulance transportation which is authorized in advance.	Ground Transportation: 30% of Eligible Expenses Air Transportation: 30% of Eligible Expenses Non-EmergencyTransportation: 30% of Eligible Expenses	Same as Network Benefit
3. Chiropractic Services Any combination of Network, Preferred and Non-Preferred Non-Network Benefits are limited to $500 per person per Policy year.	$50 per visit	50% of Eligible Expenses
4. Dental Services - Accident only	Same as 10, 14, 15, 16 and 17	Same as Network Benefit *Prior notification is required before follow-up treatment begins.
5. Dental Services - Adjunctive Benefits for dental care that is Medically Necessary and an integral part of the treatment of a Sickness or condition.	Same as 10, 14, 15, 16 and 17	Same as 10, 14, 15, 16 and 17
6. Durable Medical Equipment Any combination of Network, Preferred and Non-Preferred Non-Network Benefits for Durable Medical Equipment are limited to $2,500 per Policy year.	50% of Eligible Expenses	50% of Eligible Expenses
7. Emergency Health Services Benefits for Emergency Health Services when required for stabilization and initiation of treatment.	30% of Eligible Expenses	Same as Network Benefit
8. Home Health Care Any combination of Network, Preferred and Non-Preferred Non-Network Benefits are limited to 60 visits for skilled care services per Policy year.	30% of Eligible Expenses	50% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Preferred and Non-Preferred Non-Network Benefits / Copayment Amounts
9. Hospice Care Any combination of Network, Preferred and Non-Preferred Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	30% of Eligible Expenses	*50% of Eligible Expenses
10. Hospital - Inpatient Stay	30% of Eligible Expenses	*50% of Eligible Expenses
11. Infertility Services Any combination of Network, Preferred and Non-Preferred Non-Network Benefits for artificial insemination limited to 6 cycles per covered person during the time you are enrolled under the Policy.	50% of Eligible Expenses	50% of Eligible Expenses
12. Maternity Services	Same as 10, 14, 15 and 16 No Copayment applies to Physician office visits for prenatal care after the first visit.	*Same as 10, 14, 15 and 16 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
13. Ostomy and Urological Supplies Any combination of Network, Preferred and Non-Preferred Non-Network Benefits for ostomy and urological supplies are limited to $2,500 per Policy year.	50% of Eligible Expenses	50% of Eligible Expenses
14. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient Diagnostic Services	For preventive diagnostic lab services: No Copayment at an Alternate Facility or at a Hospital	50% of Eligible Expenses
	For preventive diagnostic radiology/ xray services: No Copayment at an Alternate Facility or at a Hospital	50% of Eligible Expenses
	For preventive mammography: No Copayment at an Alternate Facility or at a Hospital	50% of Eligible Expenses
	For Sickness and Injury related diagnostic lab services: No Copayment at an Alternate Facility or at a Hospital	50% of Eligible Expenses
	For Sickness and Injury related diagnostic radiology/xray services: No Copayment at an Alternate Facility or at a Hospital	50% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine	$100 at an Alternate Facility or at a Hospital	50% of Eligible Expenses
Outpatient Therapeutic Treatments	30% of Eligible Expenses	50% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Preferred and Non-Preferred Non-Network Benefits / Copayment Amounts
15. Physician's Office Services	For preventive medical care: $25 per visit, except that the Copayment for a Specialist Physician Office visit is $50 per visit. For sickness or injury: $25 per visit, except that the Copayment for a Specialist Physician Office visit is $50 per visit.	50% of Eligible Expenses 50% of Eligible Expenses
16. Professional Fees for Surgical and Medical Services	30% of Eligible Expenses	50% of Eligible Expenses
17. Prosthetic Devices Any combination of Network, Preferred and Non-Preferred Non-Network Benefits for prosthetic devices are limited to $2,500 per Policy year.	30% of Eligible Expenses	50% of Eligible Expenses
18. Reconstructive Procedures	Same as 10, 14, 15, 16 and 17	*Same as 10, 14, 15, 16 and 17
19. Rehabilitation Services Any combination of physical therapy, occupational therapy or speech therapy services provided on an outpatient basis, at an Inpatient Rehabilitation Facility, or in a day treatment or home setting is limited to 60 visits or 60 days whichever is greater, per Sickness or Injury. Benefits for outpatient pulmonary rehabilitation therapy is limited to 20 visits per Policy year and 36 visits per Policy year for cardiac rehabilitation.	Same as 10, 14, 15, 16 and 17	*Same as 10, 14, 15, 16 and 17
20. Skilled Nursing Facility Services Any combination of Network, Preferred and Non-Preferred Non-Network Benefits are limited to 60 days per Policy year.	30% of Eligible Expenses	*50% of Eligible Expenses
21. Temporomandibular Disorder (TMD) Services	Same as 10, 14, 15, 16 and 17	Same as 10, 14, 15, 16 and 17
22. Transplantation Services	30% of Eligible Expenses	*50% of Eligible Expenses
23. Urgent Care Center Services	$50 per visit	50% of Eligible Expenses
24. Vision Examinations Any combination of Network, Preferred and Non-Preferred Non-Network Benefits are limited to one vision examination every other Policy year.	$25 per visit	50% of Eligible Expenses

Additional Benefits

YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Preferred and Non-Preferred Non-Network Benefits / Copayment Amounts
Child Health Screenings and Immunizations	Same as 10, 14, 15, 16 and 17	Same as 10, 14, 15, 16 and 17
Diabetes Treatment	Same as 6, 10 and 15	Same as 6, 10 and 15
Habilitative Services Habilitative Services: means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy.	Same as 10, 14, 15, 16 and 17	Same as 10, 14, 15, 16 and 17
Mammography	No Copayment or Deductible applies to services for Mammography testing except for services received in connection with a Physician office visit. In this case, the Copayment shown below under Physician's Office Services will apply.	No Copayment or Deductible applies to services for Mammography testing except for services received in connection with a Physician office visit. In this case, the Copayment shown below under Physician's Office Services will apply.
Mental Health and Substance Abuse Services - Outpatient To access these services, you will need a referral from your PCP to a behavioral health clinician. The behavioral health clinician may recommend certain services that require your health plans approval and it is his or her responsibility to obtain this approval prior to you receiving the services.	For groups with 50 or less total employees: $50 per visit For groups with 51 or more total employees: $25 per visit	For groups with 50 or less total employees: 50% of Eligible Expenses For groups with 51 or more total employees: 50% of Eligible Expenses
Mental Health and Substance Abuse Services - Inpatient and Intermediate To access these services, you will need a referral from your PCP to a behavioral health clinician. The behavioral health clinician may recommend certain services that require your health plans approval and it is his or her responsibility to obtain this approval prior to you receiving the services. Any combination of Network, Preferred and Non-Preferred Non-Network Benefits for Inpatient Mental Health are limited to 60 days per Policy year. Any combination of Network, Preferred and Non-Preferred Benefits for Inpatient Substance Abuse are limited to 60 days per Policy year. Intermediate Substance Abuse Services for the purpose of detoxification are limited to 12 days per Policy year.	For groups with 50 or less total employees: 30% of Eligible Expenses For groups with 51 or more total employees: 30% of Eligible Expenses	For groups with 50 or less total employees: 50% of Eligible Expenses For groups with 51 or more total employees: 50% of Eligible Expenses

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; and other forms of alternative treatment. Alternative medical equipment, devices and supplies such as magnets or massage devices, herbs, and vitamins. Biofeedback equipment. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, including those used with Durable Medical Equipment, dehumidifiers, humidifiers, elevators, stair lifts, posture chairs, floor sitters, bathroom scales and wheelchair desks; devices or computers to assist in communication and speech and equipment for which the primary function is vocationally or educationally related such as Braille training text.

C. Dental

Routine dental treatment, X-rays, preventive care, diagnosis and treatment of or related to teeth, their supporting structures (including the jawbones and gums, unless provided for in Section 1 of the COC. Extraction, restoration and replacement of teeth, medical or surgical treatments of dental conditions, services to improve dental clinical outcomes, dental implants, bone grafts related to implant placement, orthodontic correction of malocclusion, treatment for congenitally missing, malpositioned or super numerary teeth even if part of a Congenital Anomaly, removal of maxillary and mandibular tori and exostoses unless Medically Necessary and Frenectomy, unless Medically Necessary.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care~~;~~**.** Examples include the following: Cleaning and soaking the feet, applying skin creams in order to maintain skin tone, other services that are performed when there is not a localized illness, Injury or symptom involving the foot, treatment of flat feet or subluxation of the foot; shoe orthotics and orthopedic shoes. This exclusion does not apply to therapeutic shoes for diabetics, for which Benefits are available as described in Section 1 of the COC.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies, except as described in (Section 1: What's Covered--Benefits) under the heading Diabetes Treatment. Examples include: Elastic stockings and compression garments, Ace bandages, Gauze and dressings. The following ostomy supplies: deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive removers. Orthotic appliances that straighten or re-shape a body part (including cranial banding/helmets and some types of braces). Carpal tunnel splints. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits). All over-the-counter medical equipment, devices or supplies defined as items which can be typically purchased at (including, but not limited to) a local pharmacy, supermarket, internet site, general publication or medical supply storefront and do not require a Physician's prescription for purchase. The following equipment, supplies and devices: Mobility chairs or strollers if a manual or power wheelchair is the primary means of mobility and is owned or rented by the Covered Person. Duplicate, backup or alternative equipment such as manual wheelchairs that back up power wheelchairs (the Covered Person's primary means of mobility) or a second nebulizer machine for portability. Parts and labor costs for supplies and accessories replaced due to wear and tear, such as wheelchair tires, tubes, brakes or upholstery. Scooters (power operated vehicles). Car seats, Home and vehicle modifications. Seat lifts, chairs and lift mechanisms. Manual or electronic blood pressure cuffs. Stethoscopes. Breast pumps. External penile devices. Erectaid. Cold therapy devices, icepacks, heating pads or thermal wraps. Whirlpools, wax treatment/ paraffin baths. Cervical, thoracic, lumbar or sacral pillows, wedges, supports or cushions. Physical fitness equipment, massage tables, inversion tables. Ergonomic office equipment. Home therapeutic monitoring devices such as "Coagucheck". Aids for activities of daily living such as transfer benches, grab bars, reachers, utensil holders, button zipper pulls. Personal hygiene equipment, devices or supplies such as toileting systems or hygienic assistive devices such as bath tub lifts or seats or raised toilet seats. Standing tables, adaptive positioning and assistive technology devices. Incontinent pads and diapers. Drionic (anti-sweat) devices, bed wetting control devices. Equipment, devices and supplies designed to improve self image or self esteem.

H. Mental Health/Substance Abuse

Benefits for mental health and substance abuse services are excluded for the following: Treatment for a condition that we determined. Services that are not Medically Necessary. Services when a Covered Person has either not cooperated with the treatment plan recommended by his or her behavioral health provider or signed out of a facility against the medical advice of the behavioral health provider. (Upon appeal, all such cases will be reviewed and Benefits reinstated when medically indicated.) Psychiatric therapy or psychological testing on court order or as a condition of parole or probation. Psychiatric or psychological evaluation primarily for legal or administrative purposes including, but not limited to, the determination of disability or for security clearances. Court appearances by a mental health or substance abuse provider. Testing for specific learning disabilities, intelligence, or for career aptitude and interests. Acupuncture, biofeedback and hypnotherapy for mental health or substance abuse conditions. Mental health services related to sex transformation, sterilization reversals or sexual dysfunction. Special education, counseling, therapy or care for learning deficiencies or behavioral problems. This applies whether associated with manifest mental illness or other disturbances. Confinement, treatment, services or supplies related to learning disabilities, mental retardation and/or mental deficiency. Educational assessments and vocational training. Inpatient or day treatment programs for pain management, unless deemed appropriate by us. Treatment for organic mental disorder when the disorder is due to permanent brain dysfunction. Treatment related to autism and treatment of pervasive development disorder. This exclusion does not apply to the assessment for initial diagnosis of these disorders. Treatment for sexual addiction, gambling and codependency. Sexual therapy. Treatment of sexual offenders. Treatment focused primarily on marital, child support or custody proceedings. Psychotherapy and any other consultations done by telephone. Psychoanalysis. Treatment directed towards a professional certification or whose primary purpose is personal growth and development. During inpatient hospitalizations for mental health or substance abuse treatment, services beyond one individual and up to one group session per day. Two or more levels of care that occur simultaneously including, but not limited to, inpatient Treatment and partial day hospitalization or inpatient treatment and outpatient treatment. Court ordered examinations and care. Non-Medically Necessary ancillary services, such as halfway housing.

I. Nutrition

Megavitamin and nutrition based therapy; dietary supplements, replacements or vitamins, nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Any services made necessary because of complications in connection with Cosmetic Procedures. Rhinoplasty or septorhinoplasty unless approved within 6 months of a documented nasal fracture and Sclerotherapy performed on the arms, legs, feet or hands. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight lo ss programs for medical reasons are also excluded. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography testing.

L. Reproduction

All cost associated with surrogate parenting and/or host uterus. Reversal of voluntary sterilization. All infertility services after voluntary sterilization or reversal of voluntary sterilization of either partner. In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT); costs associated with the collection, storage and harvesting of ovum or ova, embryo transfers, costs associated with the retrieval of eggs. Services provided solely to prepare for these excluded services. Costs associated with storage and cryopreservation of ova, embryo, or sperm. All costs associated with donor sperm and donor eggs. Infertility services for a non-covered spouse or partner. Sex selection, gene therapy, genetic alteration, genetic testing of embryos prior to implantation. Services, which we determine, are unlikely to result in Pregnancy.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving mechanical or animal organs. Transplant services that are not performed at a Designated Facility.

Any multiple organ transplant not listed as a Covered Health Service under the heading Transplantation Services in Section 1 of the COC. Any service associated with a non-covered transplant including, but not limited to, any service associated with complications of a non-covered transplant.

O. Travel

For Network Benefits, health services provided in a foreign country, unless required as Emergency Health Services. For Non-Network Benefits, health services provided in a foreign country unless they are not the type and nature of medical services available in the United States.

Travel or transportation expenses, even though prescribed by a Physician.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses for medical conditions or vision correction, except for Aphakia or Keratoknus, hearing aids (including bone-anchored hearing aids) ~~or~~ and any other external hearing enhancement devices, Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy and vision therapy devices. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).

Any health care service or supply that is not listed as a Covered Health Service under (Section 1: What's Covered--Benefits). Confinement, treatment, services and supplies not recommended, approved or provided by a Physician. Confinement, treatment, services and supplies rendered outside the scope of a provider's license

Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption. Related to judicial or administrative proceedings or orders. Conducted for purposes of medical research. Required to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising before the date your coverage under the Policy ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Whole blood and blood products, artificial blood products and biological serum (however Benefits are provided for the administration and autodonation). Blood products include any product which is treated from a component of blood such as, but not limited to plasma, packed red blood cells, platelets, blood clotting factors, cryoprecipitate and prolastin.

Upper and lower jawbone surgery except as required for direct treatment of temporomandibular disorder and/or related myfascial pain dysfunction syndrome, acute traumatic injury, dislocation, tumors, or cancer.

Surgical and non-surgical treatment of obesity, including morbid obesity. Surgical removal of excess skin and tissue resulting from weight loss (an example would be panniculectomy).

Abdominoplasty; Reduction mammoplasty; Growth hormone therapy; Sex transformation operations; Treatment of sexual dysfunction.

Custodial care; domicilary care; private duty nursing; respite care; rest cures.

Psychosurgery. Applied behavioral analysis; Medical and surgical treatment of gynecomastia (abnormal breast enlargement in males).

Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, autism, or a Congenital Anomaly. Speech therapy for stuttering/stammering.

Recreational activities that may be considered to serve a therapeutic purpose including, but not limited to, camp or camping events, sports or sporting events, horseback riding, art therapy services or art instruction, music therapy services or music instruction, boating or other recreational activities.

Services, therapy or supplies related to learning disabilities.

Physical, chiropractic, occupational or speech therapy determined no longer to be Medically Necessary or appropriate. Inpatient cardiac rehabilitation; Inpatient or day treatment programs for pain management.

Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing. Any charge for services, supplies or equipment advertised by the provider as free.

Any charges prohibited by federal anti-kickback or self-referral statutes.

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Optimum Choice, Inc.

A UnitedHealthcare Company

*Pharmacy Management Program **Plan 00Y***

UnitedHealthcare's pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 56,000 nationwide*) to provide convenient access to medications.

Most pharmacies participate in our network. However to confirm network participation for a particular pharmacy, we suggest that you first check with your pharmacist or visit our online pharmacy service at www.myuhc.com. The online service offers you home delivery of prescriptions, the ability to view personal benefit coverage and provides you with access to health and well being information, and even location of network retail neighborhood pharmacies by zip code.

Copayment per Prescription Order or Refill

Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. 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.

Also note that some Prescription Drug Products require that you notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

*Source: Medco Health Solutions, Inc.

	Retail Network Pharmacy For up to a 31 day supply	**Home Delivery Network Pharmacy** For up to a 90 day supply	**Retail Non-Network Pharmacy** For up to a 31 day supply
Tier 1	$10	$25.00	$10
Tier 2	$30	$75.00	$30
Tier 3	$50	$125.00	$50

Other Important Cost Sharing Information

NOTE: If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

Annual Drug Deductible	No Annual Drug Deductible
Out-of-Pocket Drug Maximum	No Out-of-Pocket Drug Maximum

Exclusions

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the following exclusions apply:

Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.

Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Any product dispensed for the purpose of appetite suppression and other weight loss products.

A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

Unit dose packaging of Prescription Drug Products.

Medications used for cosmetic purposes.

Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.

Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

Prescription Drug Products used to treat infertility, except clomiphene. Notwithstanding this exclusion, if in vitro fertilization is covered under the medical benefits, and the procedure has been authorized, Prescription Drug Products associated with its procedure are covered.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.

Prescription Drug Products for smoking cessation.

Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.

New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Prescription Drug List Management Committee.

Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).