OPTIMUM CHOICE, Inc. *Plan GHA*

A UnitedHealthcare Company

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

To access specialty services, you will need a referral from your Primary Care Physician (PCP). PCP's 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.

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.

Some of the Important Benefits of Your Plan Provided by Your PCP:

Preventive health care including: childhood immunizations, mammograms, vision and hearing screenings. Office visits for sickness and injury

Health care education

Your PCP is responsible for arranging or coordinating your care, including giving you a referral for specialty care.

Optimum Choice, Inc. *Benefits Summary*

Types of Coverage	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.**	**Network Annual Deductible:** No Annual Deductible
If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.	**Network Out-of-Pocket Maximum:** $2,900 per Covered person per policy year, not to exceed $8,700 for all Covered Persons in a family. Except for the Emergency Services Copayment, no Copayment applies toward the satisfaction of the Annual Deductible or Out-of-Pocket.
Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.	**Maximum Policy Benefit:** No Lifetime Maximum
Network health care services under this benefit plan are covered only when provided, arranged, or authorized by a Network Physician.	
1. Care in medical offices for treatment of Illness or Injury	$10 for Primary Care Services. $20 for Specialty Care Services.
2. Well-Child Visits	$10 per well child visit for all visits for children 0 to 24 months of age; $10 per well child visit for visits that include immunizations for children aged 24 months through 13 years; For all other visits $30 per visit.
3. Inpatient Hospital Services	0% of Eligible Expenses
4. Physician Inpatient Hospital Visits	$10
5. Outpatient Hospital Service and Surgery	$20
6. Mental Health and Substance Abuse Services-Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Netowrk Benefits are limited to 60 days per policy year. Any ombination of Preferred and Non-Preferred Non-Network Netowrk Benefits are limited to 60 days per policy year.	0% of Eligible Expenses
7. Mental Health and Substance Abuse-- Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Note: Office Visits for the purpose of medication management are paid on the same as described above under 1.Care in medical offices for treatment of Illness or Injury.	30% of Eligible Expenses
8. Emergency Services	$100 per visit (waived if Emergency visit results in Hospital admission).
9. Urgent Care	$10 for Primary Care Services. $20 for Specialty Care Services.
10. Detoxification in a hospital or related institution	0% of Eligible Expenses for inpatient hospital services. $30 for outpatient hospital services.
11. Ambulance Services	0% of Eligible Expenses
12. Preventative Services	$10 for Primary Care Services. $20 for Specialty Care Services.
13. Prostate Cancer Screening/Colorectal Cancer	$10 for Primary Care Services. $20 for Specialty Care Services. $20 Copayment or 50% the cost of the screening service, whichever is less.
14. Mammography Services	$20 Copayment or 50% the cost of the screening service, whichever is less.
15. Home Health Care Services	0% of Eligible Expenses
16. Hospice Care Services	0% of Eligible Expenses
17. Durable Medical Equipment	0% of Eligible Expenses
18. Outpatient Laboratory and Diagnostic Services	$20 or 50% the cost of service, whichever is less.
19. Bone Mass Measurement	$10 for Primary Care Services. $20 for Specialty Care Services. $20 Copayment or 50% the cost of the screening service, whichever is less.

Types of Coverage	Network Benefits / Copayment Amounts
20. Rehabilitation Services – Outpatient Therapy Network Benefits are limited as follows: 30 visits of physical therapy; 30 visits of occupational therapy; and 30 visits of speech therapy per policy year. Any ombination of Preferred and Non-Preferred Non-Network Benefits are limited as follows: 30 visits of physical therapy; 30 visits of occupational therapy; and 30 visits of speech therapy per policy year.	$20 per visit
21. Chiropractic Services Network Benefits are limited to 20 visits per policy year. Any combination of Preferred and Non-Preferred Non-Network Benefits are limited to 20 visits per policy Year.	$20 per visit
22. Skilled Nursing Facility Network Benefits are limited to 100 days per policy year. Any combination of Preferred and Non-Preferred Non-network to 100 days per policy year.	$20 per day
23. Infertility Services	50% of Eligible Expenses after the diagnosis of infertility has been confirmed.
24. Nutritional Services Treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease up to a maximum of 6 visits per policy year per condition for Network. Treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease up to a maximum of 6 visits per policy year per condition for Any combination of Preferred and Non-Preferred Non-network to 100 days per policy year.	$10 for Primary Care Services. $20 for Specialty Care Services.
25. Transplantation Services	0% of Eligible Expenses
26. Medical Foods	0% of Eligible Expenses
27. Family Planning Services Including: Prescription contraceptive drugs or devices and voluntary sterilization.	$10 for Primary Care Services. $20 for Specialty Care Services.
28. Habilitative Services	$10 for Primary Care Services. $20 for Specialty Care Services.
29. Blood Products	0% of Eligible Expenses
30. Pregnancy and Maternity Services	0% of Eligible Expenses or $40 for services of a nurse-midwife if delivery is outside a hospital.
31. Prescription Drugs. Prescription drugs include birth control drugs and diabetic supplies – insulin syringes, needles, and testing strips for glucose monitoring equipment, are covered. Coverage of up to 90-day supply of maintenance drugs in a single dispensing is not required for the first prescription of a maintenance drug or a change in a prescription of a maintenance drug.	Please see Pharmacy Benefit Summary for Plan Details.
32. Controlled Clinical Trials Note: Per Maryland State law, any Service Area and/or Network restrictions stated in this Certificate do not apply to Clinical Trials.	$10 for Primary Care Services. $20 for Specialty Care Services.
33. Services Approved by a Carrier's Case Management Program	$10 for Primary Care Services. $20 for Specialty Care Services.
34. Diabetes Treatment, Equipment and Supplies	$10 for Primary Care Services. $20 for Specialty Care Services for diabetes treatment. Note: Equipment obtained under Durable Medical Equipment are subject to the Copayments shown under 17. Note: Supplies obtained at a pharmacy are subject to the Copayments shown under 31.
35. Reconstructive Breast Surgery and Breast Prosthesis	0% of Eligible Expenses
36. Audiology Screening for Newborns	$20 or 50% of the cost of the service, whichever is less
37. Dental Anesthesia and Hospital Services	$20
38. Chlamydia Screening	$20 or 50% the cost of the screening service, whichever is less.

Types of Coverage	Network Benefits / Copayment Amounts
39. Hearing Aids Network Benefits are limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months for ages 0-18 years. Any combination of Preferred and Non-Preferred Non-Network Benefits are limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months for ages 0-18 years	0% of Eligible Expenses
40. Ostomy Supplies Benefits for ostomy supplies including only the following: Pouches, face plates, belts, irrigation sleeves, bags, catheters and skin barriers.	0% of Eligible Expenses
41. Eye Examinations	$10 per visit
42. Surgical Treatment of Morbid Obesity	0% of Eligible Expenses

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: Covered Health Services) or through a Rider to the Certificate.

Services that are not medically necessary.

Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.

Services that are beyond the scope of practice of the Health Care Practitioner performing the service.

Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for Services received for which the recipient is liable.

Services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.

The purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury.

Personal Care services and Domiciliary services.

Services rendered by a Health Care Practitioner who is the Covered Person’s spouse, mother, father, daughter, son, brother or sister.

Experimental Services.

Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transplant, or cryogenic or other preservation techniques used in these or similar procedures.

Services to reverse a voluntary sterilization procedure.

Services for sterilization or reverse sterilization for a Dependent minor.

Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services.

Services incurred before the effective date of Coverage for a Covered Person.

Services incurred after a Covered Person's termination of Coverage, including any extension of benefits.

Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

Services for injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a worker's compensation law.

Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

Personal hygiene and convenience items including, but not limited to air conditioners, humidifiers, or physical fitness equipment.

Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.

Inpatient admissions primarily for diagnostic studies, unless authorized by the Company.

The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers. This exclusion does not include hearing aids for minor children as described above in Section 1.

Except for Covered Ambulance Services, travel, whether or not recommended by a Health Care Practitioner.

Except for Emergency Services, services received while the Covered Person is outside the United States.

Immunizations related to foreign travel.

Unless otherwise specified in Section 1, dental work or treatment which includes Hospital or professional care in connection with:

The operation or treatment for the fitting or wearing of dentures;

Orthodontic care of malocclusions; and operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the accident occurs while the patient is insured and the treatment is received within 6 months of the accident.

Dental implants.

Accidents occurring while and as a result of chewing.

Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these Services are determined to be medically necessary.

Arch support, orthotic devices, in -shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be medically necessary.

Inpatient admissions primarily for physical therapy, unless authorized by us.

Treatment leading to or in connection with transsexualism, or sex changes or modification, including but not limited to surgery.

Treatment of sexual dysfunction not related to organic disease.

Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.

Organ transplants except those specifically stated as Covered service.

Nonhuman organs and their implantation.

Nonreplacement fees for blood and blood products.

Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a covered service.

Wigs or cranial prosthesis.

Weekend admission charges, except for emergencies and maternity, unless authorized by us.

Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.

Temporomandibular joint syndrome (TMJ) treatment and treatment for cranionmandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if medically necessary and there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.

Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the Services are payable under a medical expense payment provisions of an automobile insurance policy.

Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.

Services for, or related to, the removal of an organ from a Covered Person for purposes of transplantation into another person, unless the:

a. transplant recipient is Covered under the Plan and is undergoing a Covered transplant; and

b. services are not payable by another carrier.

Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

Private Hospital room, unless authorized by us.

Private duty nursing, unless authorized by us.

Treatment for mental health or substance abuse not authorized by us through our Mental Health/Substance Abuse Designee, or mental health or substance abuse condition determined by us through our Mental Health/Substance Abuse Designee to be untreatable.

Services related to smoking cessation.

Benefits are not available for gauze, adhesive remover, deodorant, pouch covers, or other items not listed as covered.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by us, the applicable payment for Eligible Expenses is set forth under Section 19-710.1 of the Maryland Health General Article.

Experimental Services - services that are not recognized as efficacious as that term is defined in the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. "Experimental services" do not include Controlled Clinical Trials as defined above.

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.

** For Maintenance Medications, as written by the provider: Per 90 day supply for mail order and retail drugs, the payment of a Copayment of up to 2.5 times the Copayment for a 31 day supply.

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/ Maintenance ** For up to a 31 day supply	**Home Delivery Network Pharmacy** For up to a 90 day supply	**Retail Non-Network Pharmacy/Maintenance **** 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. This Exclusion does not apply to the off-label use of a drug if such drug is recognized for treatment in any of the standard reference compendia or in the medical literature.

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.

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 and assigned to a tier by our Prescription Drug List Management Committee. However, we will provide immediate coverage for a New Prescription Drug Product if, in the judgment of the Authorized Prescriber: There is no equivalent Prescription Drug Product on the Prescription Drug List; or An equivalent Prescription Drug Product on the Prescription Drug List: has been ineffective in treating the Subscriber's disease or condition; or has caused or is likely to cause an adverse reaction or other harm to the Subscriber.

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