OPTIMUM CHOICE, Inc. Preferred *Plan 1IR*

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:** No Annual Deductible. **Out-of-Pocket Maximum:** $2,000 per Covered Person per policy year, not to exceed $6,000 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 $3,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $4,000 per Covered Person per policy year, not to exceed $8,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does 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	20% of Eligible Expenses
2. Ambulance Services Benefits are provided for Medically Necessary Non-Emergency ambulance transportation which is authorized in advance.	Ground Transportation: No Copayment Air Transportation: No Copayment Non-Emergency Transportation: No Copayment	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	20% 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. This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	50% of Eligible Expenses	50% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Preferred and Non-Preferred Non-Network Benefits / Copayment Amounts
7. Emergency Health Services Benefits for Emergency Health Services when required for stabilization and initiation of treatment.	$150 per visit	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.	No Copayment	20% of Eligible Expenses
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.	No Copayment	*20% of Eligible Expenses
10. Hospital - Inpatient Stay	$500 per Inpatient Stay	*20% 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	$250 per surgical procedure	20% of Eligible Expenses
Outpatient Diagnostic Services	For preventive diagnostic lab services: No copayment	20% of Eligible Expenses
	For preventive diagnostic radiology/ xray services: No copayment	20% of Eligible Expenses
	For preventive mammography: No copayment	20% of Eligible Expenses
	For Sickness and Injury related diagnostic lab services: $500 per visit	20% of Eligible Expenses
	For Sickness and Injury related radiology/xray services: $500 per visit	20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	$150 per visit	20% of Eligible Expenses
Outpatient Therapeutic Treatments	No Copayment	20% 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: No Copayment For sickness or injury: $25 per visit, except that the Copayment for a Specialist Physician Office visit is $50 per visit.	20% of Eligible Expenses 20% of Eligible Expenses
16. Professional Fees for Surgical and Medical Services	No Copayment	20% 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. This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	50% 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 Benefits are available only for rehabilitation services that we determine can be expected to result in significant physical improvement in your condition within 90 days of the start of treatment. Any combination of Network Benefits, Preferred and Non-Preferred Non-Network Benefits is limited as follows: 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 90 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 Any combination of Network, Preferred and Non-Preferred Non-Network Benefits are limited to 60 days per Policy year.	No Copayment	*20% of Eligible Expenses
21. Temporomandibular Disorder Services	Same as 10, 14, 15, 16 and 17	Same as 10, 14, 15, 16 and 17
22. Transplantation Services	No Copayment	*20% of Eligible Expenses
23. Urgent Care Center Services	$75 per visit	20% 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	20% of Eligible Expenses

Additional Benefits

Types of Coverage	Network Benefits / Copayment Amounts	Preferred and Non-Preferred Non-Network Benefits / Copayment Amounts
Biologically Based Mental Illness: Diagnosis and treatment of biologically based mental illness as defined in Section 10 when provided by or under the direction of a Physician.	Same as 10, 14, 15 and 16	Same as 10, 14, 15 and 16
Cleft Lip and Cleft Palate Treatment	Same as 5, 10, 14, 15 and 16	Same as 5, 10, 14, 15 and 16
Clinical Trials for Treatment Studies on Cancer	Same as 10, 14, 15 and 16	Same as 10, 14, 15 and 16
Dental Services - Hospital and Alternate Facility Health Services Related to Dental Care	Same as 10, 14, 15 and 16	Same as 10, 14, 15 and 16
Diabetes Treatment	Same as 6, 10 and 15	Same as 6, 10 and 15
Early Intervention Services	$50 per visit for outpatient therapy. No Copayment for assistive technology services and devices.	20% of Eligible Expenses
Hearing Aids Benefits for hearing aids are limited to $2,500 per Policy year and are limited to a single purchase (including repair/replacement) every three years.	No Copayment	20% of Eligible Expenses
Hemophilia and Congenital Bleeding Disorders	Same as 10, 14, 15 and 16	Same as 10, 14, 15 and 16
Mammography	Same as 14 and 15	Same as 14 and 15
Mental Health Services 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 plan's 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: Any combination of Network and Non-Network Benefits for Inpatient/Intermediate Mental Health Services are limited to 20 days per year for adult Covered Persons and 25 days for an Enrolled Dependent child. Any combination of Network and Non-Network Benefits for Outpatient Mental Health Services are limited to 20 visits per year. Benefit limits do not apply to outpatient visits for medication management. Benefit limits do not apply to Mental Health Services for Biologically Based Mental Illness.	For groups with 50 or less total employees: Non-Biologically Based Mental Illness Inpatient: $500 per Inpatient Stay Outpatient: $50 per visit When outpatient visits are subject to payment of a Copayment, the Copayent will not exceed 50% of Eligible Expenses.	For groups with 50 or less total employees: Non-Biologically Based Mental Illness Inpatient: 20% of Eligible Expenses Outpatient: 20% of Eligible Expenses
For groups with 51 or more total employees: Benefit limits do not apply.	For groups with 51 or more total employees: Inpatient: $500 per Inpatient Stay Outpatient: $25 per visit When outpatient visits are subject to payment of a Copayment, the Copayment will not exceed 50% of the Eligible Expenses.	For groups with 51 or more total employees: Inpatient: 20% of Eligible Expenses Outpatient: 20% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Preferred and Non-Preferred Non-Network Benefits / Copayment Amounts
Neurobiological Disorders - Autism Spectrum Disorder Services 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 plan's 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: Any combination of Network and Non-Network Benefits for Inpatient/Intermediate Neurobiological Disorders - Autism Spectrum Disorder Services are limited to 20 days per year for adult Covered Persons and 25 days for an Enrolled Dependent child. Any combination of Network and Non-Network Benefits for Outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to 20 visits per year.	For groups with 50 or less total employees: Non-Biologically Based Mental Illness Inpatient: $500 per Inpatient Stay Outpatient: $50 per visit When outpatient visits are subject to payment of a Copayment, the Copayent will not exceed 50% of Eligible Expenses.	For groups with 50 or less total employees: Non-Biologically Based Mental Illness Inpatient: 20% of Eligible Expenses Outpatient: 20% of Eligible Expenses
For groups with 51 or more total employees: Benefit limits do not apply.	For groups with 51 or more total employees: Inpatient: $500 per Inpatient Stay Outpatient: $25 per visit When outpatient visits are subject to payment of a Copayment, the Copayment will not exceed 50% of the Eligible Expenses.	For groups with 51 or more total employees: Inpatient: 20% of Eligible Expenses Outpatient: 20% of Eligible Expenses
Prostate and Colorectal Cancer Screenings	Same as 14, 15 and 16	Same as 14, 15 and 16

Types of Coverage	Network Benefits / Copayment Amounts	Preferred and Non-Preferred Non-Network Benefits / Copayment Amounts
Substance Use Disorder Services 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 plan's 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: Any combination of Network and Non-Network Benefits for Inpatient/Intermediate Substance Use Disorder Services are limited to 20 days per year for adult Covered Persons and 25 days for an Enrolled Dependent child. Any combination of Network and Non-Network Benefits for Outpatient Substance Use Disorder Services are limited to 20 visits per year.	For groups with 50 or less total employees: Non-Biologically Based Mental Illness Inpatient: $500 per Inpatient Stay Outpatient: $50 per visit When outpatient visits are subject to payment of a Copayment, the Copayent will not exceed 50% of Eligible Expenses.	For groups with 50 or less total employees: Non-Biologically Based Mental Illness Inpatient: 20% of Eligible Expenses Outpatient: 20% of Eligible Expenses
For groups with 51 or more total employees: Benefit limits do not apply.	For groups with 51 or more total employees: Inpatient: $500 per Inpatient Stay Outpatient: $25 per visit When outpatient visits are subject to payment of a Copayment, the Copayment will not exceed 50% of the Eligible Expenses.	For groups with 51 or more total employees: Inpatient: 20% of Eligible Expenses Outpatient: 20% 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; aromatherapy; 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, 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 and 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. There are three exceptions: Services provided under Section 1: What's Covered--Benefits) under the heading Clinical Trials for Treatment Studies on Cancer; No prescribed drug shall be excluded as Experimental, Investigational or Unproven on the basis that the drug has not been approved by the Food and Drug Administration (FDA) for the treatment of the specific condition for which the drug has been prescribed, provided that: 1) the drug has been approved by the FDA for at least one indication and 2) the drug has been recognized as safe and effective for treatment of the specific condition in either of the following standard reference compendia: the American Hospital Formulary Service Drug Information or the United States Pharmacopoeia Dispensing Information; and Benefits for any drug approved by the FDA for use in the treatment of cancer pain are covered even if the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed for a patient with intractable cancer pain.)

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; treatment of flat feet or subluxation of the foot; shoe orthotics and orthopedic shoes.

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

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders-Autism Spectrum Disorder Services in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.

Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

I. Neurobiological Disorders - Autism Spectrum Disorders

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.

Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

J. 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.

K. 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. 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 for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

L. Providers

Services performed by a provider with your same legal residence or 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.

M. 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.

N. 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.

O. Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

P. 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. 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 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.

Q. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.
Travel or transportation expenses, even though prescribed by a Physician.

R. Vision and Hearing

Purchase cost of eye glasses, contact lenses for medical conditions or vision correction, except for Aphakia or Keratoknus, hearing aids or 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.

S. 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). Procedures provided outside the Service Area except for Emergency Health Services and Covered Health Services received in Urgent Care Situations, unless approved by us. Services from non-Network providers unless specifically authorized by us, except for Emergency Health Services and Covered Health Services received in Urgent Care Situations.
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.
Deliveries that occur while the mother is outside the Service Area during the last trimester of Pregnancy, unless authorized by us.
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 prohibited by federal anti-kickback or self-referral statutes.
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.	GHMO.POS.VA RXGHMO4TIER.H.06.VA

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. However, even if the supply limit is exceeded, Benefits are provided for any drug approved by the FDA for use in the treatment of cancer pain if the prescription in excess of the supply limit has been prescribed for a patient with intractable cancer pain.

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.There are two exceptions: No prescribed drug shall be excluded as Experimental, Investigational or Unproven on the basis that the drug has not been approved by the Food and Drug Administration (FDA) for the treatment of the specific condition for which the drug has been prescribed, provided that: 1) the drug has been approved by the FDA for at least one indication and 2) the drug has been recognized as safe and effective for treatment of the specific condition in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; and Benefits for any drug approved by the FDA for use in the treatment of cancer are covered even if the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia. "Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier. "Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

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 and assigned to a tier by our Prescription Drug List Management Committee except that such review and approval of new Prescription Drug Products and/or new dosage forms will not be required for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. The standard reference compendia are noted above under the Experimental, Investigational or Unproven Services Exclusion.

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

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