

It just makes sense.SM

OPTIMUM
CHOICE, INC.SM
A UnitedHealthcare[®] Company

24/7 Member Services 1-800-605-8202
4 Taft Court • Rockville, MD 20850
www.mamsiUnitedHealthcare.com

10 01 17 122 8/05

OPTIMUM
CHOICE, INC.SM
A UnitedHealthcare[®] Company[®]

*Prince George's
County Government and
Memorial Library*

summary

HMO and POS Health Benefits – Plan Year 2006



HMO (In-Plan) Benefits At-A-Glance

Benefits	In-Plan Benefit ¹
Annual Deductible	None
Lifetime Maximum	None
Physician Office Visits	
Primary Care Physician	100% after \$15 Copayment per visit
Specialist Physician	100% after \$20 Copayment per visit
Preventive Care	
Routine Physical	100% after \$15 Copayment per visit
Annual GYN Exam (no PCP referral needed at Participating OB/GYN or Nurse Midwife)	100% after \$20 Copayment per visit for OB/GYN No Copayment for Nurse Midwife
Mammograms	100% after \$20 Copayment
Well Child Visits (including immunizations)	100% after \$15 Copayment
Hospital Care	
Inpatient Facility Services	100% after \$100 Copayment per Admission
Inpatient Physician Services	No Copayment
Outpatient Surgery and Other Outpatient Services	100% after \$50 Copayment
Emergency Care²	
Hospital Emergency Room	100% after \$50 Copayment per visit
Urgent Care Center	100% after \$50 Copayment per visit
Ambulance Service	No Copayment
Occupational, Physical and Speech Therapy	100% after \$20 Copayment per visit; 60 visits per therapy type per condition
Outpatient Diagnostic Laboratory/X-rays/Testing	100% after \$20 Copayment per visit
Maternity Care	
Routine OB Office Visits	100% after \$20 Copayment for first visit ³
Inpatient Care	100% after \$100 Copayment per Admission
Hospice Care	No Copayment (up to 180 days)
Home Health Care	No Copayment
Skilled Nursing Facility	No Copayment; maximum 120 days per Contract Year
Mental Health/Chemical Dependency	
Inpatient	100% after \$100 Copayment per Admission
Outpatient	100% after \$20 Copayment per visit
Durable Medical Equipment	No Copayment for covered services and supplies
Chiropractic Care	100% after \$20 Copayment; 20 visits per Contract Year
Acupuncture	100% after \$20 Copayment

¹ All medical care must be provided or coordinated by your Primary Care Physician (except for emergencies). All elective hospitalizations, Durable Medical Equipment, and some outpatient services require Pre-certification/Pre-admission Authorization.

² Copayment waived if member is admitted to the hospital, in which case the inpatient hospitalization Copayment applies. Services that do not meet OCI's definition of emergency are not covered.

³ Routine services consist of office visits, one office sonogram (as part of pre-natal care) and laboratory work; other non-routine services are subject to the applicable Copayment for each visit.

POS[†] Benefits At-A-Glance

Benefits	In-Plan (HMO) Benefit ^A	Out-of-Plan (POS) Benefit ^B
Annual Deductible	None	\$250 Individual/\$500 Family per Contract Year
Lifetime Maximum	None	\$1,000,000
Physician Office Visits		
Primary Care Physician	100% after \$15 Copayment per visit	80% after deductible
Specialist Physician	100% after \$20 Copayment per visit	80% after deductible
Preventive Care		
Routine Physical	100% after \$15 Copayment per visit	80% after deductible
Annual GYN Exam (no PCP referral needed at Participating OB/GYN or Nurse Midwife)	100% after \$20 Copayment per visit for OB/GYN No Copayment for Nurse Midwife	80% after deductible
Mammograms	100% after \$20 Copayment	80% after deductible
Well Child Visits (immunizations)	100% after \$15 Copayment	80% after deductible
Hospital Care		
Inpatient Facility Services	100% after \$100 Copayment per Admission	80% after deductible
Inpatient Physician Services	No Copayment	80% after deductible
Outpatient Surgery and Other Outpatient Services	100% after \$50 Copayment	80% after deductible
Emergency Care^C		
Hospital Emergency Room	100% after \$50 Copayment per visit	Services received at an Emergency Room which meet the Plan's definition of an emergency are payable In-Plan.
Urgent Care	100% after \$50 Copayment per visit	80% after deductible
Ambulance Service	No Copayment	80% after deductible
Occupational, Physical and Speech Therapy	100% after \$20 Copayment per visit; 60 visits per therapy type per condition	80% after deductible; 60 visits per therapy type per condition
Outpatient Diagnostic Laboratory/X-rays/Testing	100% after \$20 Copayment per visit	80% after deductible
Maternity Care		
Routine OB Office Visits	100% after \$20 Copayment for first visit ^D	80% after deductible
Inpatient Care	100% after \$100 Copayment per Admission	80% after deductible
Hospice Care	No Copayment (up to 180 days)	80% after deductible (up to 180 days)
Home Health Care	No Copayment	80% after deductible
Skilled Nursing Facility	No Copayment; maximum 120 days per Contract Year	80% after deductible; maximum 120 days per Contract Year
Mental Health/Chemical Dependency		
Inpatient	100% after \$100 Copayment per Admission	80% after deductible
Outpatient	100% after \$20 Copayment per visit	80% after deductible for visits 1-30 65% after deductible for visits 31+
Durable Medical Equipment	No Copayment for covered services and supplies	80% after deductible
Chiropractic Care	100% after \$20 Copayment; 20 visits per Contract Year	80% after deductible; 20 visits per Contract Year
Acupuncture	100% after \$20 Copayment	80% after deductible

^A All medical care must be provided or coordinated by your Primary Care Physician (except for emergencies). All elective hospitalizations, some outpatient services and Durable Medical Equipment require Pre-certification/Pre-admission Authorization.

^B Out-of-Plan benefits are provided for covered services through MAMSI Life and Health Insurance Company (MLH) and do not require referral or coordination by your Primary Care Physician. Participating Providers have agreed to accept the Plan's payment plus your deductible and co-insurance as full payment. If you choose a non-Participating Provider, the Plan is responsible for payment of the applicable percentage of either the Requested Charge or the Usual, Customary and Reasonable Charge, whichever is less. You will be responsible for any applicable deductible and co-insurance plus the balance, if any, of the non-Participating Provider's Charges. **All benefit limits stated under the Out-of-Plan benefit are combined with those limits stated In-Plan.** All elective hospitalizations, durable medical equipment and some outpatient services require Pre-admission Authorization.

^C Copayment waived if Member is admitted to the hospital, in which case the inpatient hospitalization copayment applies. Services that do not meet OCI's definition of an emergency are not covered.

^D Routine services consist of office visits, one office sonogram (as part of pre-natal care) and laboratory work; other non-routine services are subject to the applicable Copayment for each visit.

[†] Annual out-of-pocket maximums: Actives and Retirees-Single \$2,000, Family \$4,000. The out-of-pocket maximum includes annual deductibles and amounts in excess of the percentage payable for covered medical services up to the Usual, Customary and Reasonable Charge authorized by MLH.

This document is intended as a summary only. For complete details, please consult your OCI EOC Form #0401239-0103MD and MLH POS Group Certificate Form #: 0726254-0103 MD.