

# M.D. IPA<sup>SM</sup>

## A UnitedHealthcare<sup>®</sup> Company

### **HMO Plan (MD012BQ\*KH00)**

The MD-Individual Practice Association, Inc. HMO plan provides you with medical coverage through a network of participating physicians and other health care practitioners. To access specialty services, you will need a referral from your Primary Care Physician (PCP). PCPs usually specialize in family or general practice, internal medicine, obstetrics/gynecology (OB/GYN) or pediatrics. Each of your family members may choose a different PCP, and you can change your PCP as often as monthly.

Most of your medical care must be arranged and coordinated by your PCP. Your PCP will provide:

- Office visits when you are ill
- Preventive health care
- Immunizations for children and adults
- Health care education

Your PCP is also responsible for:

- Writing referrals for specialty care
- Arranging for hospitalizations
- Approving urgent care
- Arranging for behavioral health and substance abuse care
- Arranging for laboratory and X-ray services
- Arranging for outpatient services and surgery

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 our Member Services Department for further assistance.

### ***Some of the Important Benefits of the HMO Plan:***

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- You have access to a network of participating providers, including hospitals and specialists. Look on our Web site, [www.mamsiUnitedHealthcare.com](http://www.mamsiUnitedHealthcare.com), to see our network of participating providers.
- Benefits include coverage for office visits and hospital care, including inpatient and outpatient surgery.
- Preventive services are covered including:
  - Childhood immunizations
  - Well-woman services (e.g., pap smears, mammograms)
- Prenatal care
- Routine check-ups
- Vision and hearing screening

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### **Health Benefits Summary**

#### **Important Information**

- This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine your coverage. This Plan may not cover all of your health care expenses. **More complete descriptions of your benefits and the terms under which your benefits are provided are contained in the Evidence of Coverage (EOC) that you will receive upon enrolling in the Plan.**
- If this Benefit Summary conflicts in any way with your EOC, the EOC shall prevail.
- Terms that are capitalized in the Benefit Summary are defined in your EOC.
- Benefits are payable for Covered Services (except emergency services) coordinated and/or arranged by your Primary Care Physician.
- All exclusions and limitations applicable to this Plan are described in your EOC.
- **Annual Deductible: No Deductible.**
- **Out-of-Pocket Maximum:** Copayments for some Covered Services may not apply to the Out-of-Pocket Maximum as specified in the Evidence of Coverage. See grid below:

	<b>Out-of-Pocket Maximum For 2 Tier Rate Structure</b>	<b>Out-of-Pocket Maximum For 3 Tier Rate Structure</b>	<b>Out-of-Pocket Maximum For 4 Tier Rate Structure</b>	<b>Out-of-Pocket Maximum For 5 Tier Rate Structure</b>
<b>Single</b>	\$1,700	\$1,700	\$1,700	\$1,700
<b>Employee/Spouse</b>	\$4,600	\$3,200	\$3,200	\$3,200
<b>Employee/Child</b>	\$4,600	\$3,200	\$2,900	\$3,200
<b>Family</b>	\$4,600	\$5,200	\$5,200	\$5,200
<b>Employee/Children</b>	\$4,600	\$5,200	\$5,200	\$4,000

#### **Types of Coverage**

<b>HMO Benefits:</b>	<b>You Pay:</b>
<b>1. Acupuncture</b>	\$15.00 Copayment up to 12 visits per Contract Year and is covered only for postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, postoperative dental pain and as part of a comprehensive treatment program for chronic pain.
<b>2. Chiropractic Visits</b>	50% Copayment of Charges up to \$500.00 per Member per Contract Year.
<b>3. Circumcision</b>	Covered In Full.

Plan offered by: MD-Individual Practice Association Inc. (MD. IPA)  
 4 Taft Court.  
 Rockville, MD 20850  
[www.mamsiUnitedHealthcare.com](http://www.mamsiUnitedHealthcare.com)

Rider Package: MD012BQ\*KH00 (7B\*KH + 38.1927 + 38.905 + 38.917)  
 EOC Form Number: 0101155-0498MD

<b>HMO Benefits:</b>	<b>You Pay:</b>
<b>4. Covered Transplants</b>	Heart, heart/lung, lung, liver, pancreas, kidney, cornea and all non-experimental bone marrow transplants when deemed Medically. Requires Preadmission Authorization & Precertification. Member must meet certain criteria. Subject to Applicable Copayment/Deductible.
<b>5. Diagnostic Lab Tests</b>	Applicable Copayment
<b>6. Emergency Room Visits (no referral necessary)</b>	\$25.00 Copayment for services that meet the Plan's definition of Emergency Services. Copayment is waived if the Member is admitted to the Hospital, in which case, the Inpatient Hospital Deductible and Copayment apply (if there is an Inpatient Hospital Copayment or Deductible). Services that do not meet the Plan's definition of Emergency Services are not covered.
<b>7. Eye Refraction Examination (no referral necessary)</b>	\$25.00 Copayment (No referral necessary to a Participating Provider)
<b>8. Hospital- Inpatient Stay</b>	Covered In Full. Requires Preadmission Authorization.
<b>9. Mammography Examinations</b>	Applicable Copayment
<b>10. Maternity Care</b>	\$15.00 Copayment; all other non-office visit copayments apply.
<b>11. Medication management office visit associated with mental health or substance abuse</b>	\$15.00 Copayment
<b>12. Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse- Inpatient -</b>	Covered In Full. Requires Preadmission Authorization.
<b>13. Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse - Outpatient</b>	20% Copayment of Charges per visit 1-5; 35% Copayment of Charges per visit for visits 6-30; 50% Copayment of Charges per visit thereafter.
<b>14. OB/GYN Office Visits (no referral necessary)</b>	\$15.00 Copayment- Female Members may have direct access to a Participating OB/GYN or a Participating Certified Nurse/Midwife without a referral from the Member's PCP for Medically Necessary OB/GYN care, including, but not limited to, routine care. If the Member requires the services of another Specialty Provider, the Member's PCP must determine the necessity of a referral. No Copayment required for Participating Certified Nurse/Midwife services
<b>15. Occupational, and Physical Therapy Visits</b>	\$15.00 Copayment up to 60 visits per incident or injury. These limits are combined with the limits stated under Speech Therapy.
<b>16. Outpatient Hospital Services</b>	\$25.00 Copayment
<b>17. Outpatient Hospital Surgery</b>	\$25.00 Copayment
<b>18. Partial Hospitalization Mental health/Substance abuse</b>	\$25.00 Copayment up to 60 days per Contract Year.
<b>19. Primary Care Physician Office Visits</b>	\$10.00 Copayment
<b>20. Routine Physical Exam</b>	\$10.00 Copayment for covered services
<b>21. Skilled Nursing Facility</b>	Covered In Full up to 60 days per Member per

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<b>HMO Benefits:</b>	<b>You Pay:</b>
	Contract Year, Requires Preadmission Authorization.
<b>22. Specialist Office Visits</b>	\$15.00 Copayment
<b>23. Speech Therapy</b>	\$15.00 Copayment up to 60 visits per Condition. These limits are combined with the limits stated under Occupational and Physical Therapy. Visit limit does not apply to the treatment of cleft lip/cleft palate or both.
<b>24. Urgent Care Facility Visits</b>	\$15.00 Copayment
<b>25. Well Child Care</b>	\$10.00 Copayment for covered services
<b>26. X-rays</b>	Applicable Copayment

<b>Additional Benefits:</b>	<b>You Pay:</b>
<b>Ambulance Service</b>	Covered in Full when Medically Necessary. Requires Preauthorization.
<b>Durable Medical Equipment</b>	50% Copayment of Charges. Requires Prior Authorization.
<b>Habilitative Services for Children under Age 19</b>	\$15.00 Copayment for Occupational, Physical and Speech Therapy for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the child's ability to function (coverage not provided if services are delivered through Early Intervention or School Services).
<b>Hair Prosthesis</b>	50% Copayment of Charges-One Hair Prosthesis will be covered for a Member whose hair loss results from chemotherapy or radiation treatment for cancer when prescribed by the Oncologist in attendance (the cost shall not exceed \$350.00 and is limited to one Hair Prosthesis per lifetime). Requires Prior Authorization.
<b>Hearing Aid for Children under 19</b>	50% Copayment of Charges up to \$1,400 per ear every 36 months if the hearing aid is prescribed, fitted and dispensed by a participating licensed audiologist.
<b>Home Health Care</b>	Covered In Full.
<b>Hospice Care</b>	Covered In Full. Requires Preadmission Authorization.
<b>Infertility Treatment – Artificial Insemination</b>	50% Copayment of Charges (limited to 6 cycles per lifetime).
<b>Infertility Services – In Vitro Fertilization</b>	50% Copayment of Charges (limited to 3 attempts per live birth, not to exceed a maximum lifetime limit of \$100,000); the Member must meet certain criteria.
<b>Initial Allergy Consultation</b>	Applicable Physician Copayment applies
<b>Norplant Services</b>	Applicable Physician Copayment applies
<b>Orthopedic Braces</b>	50 % Copayment of Charges. Requires Prior Authorization.
<b>Tubal Ligation Services</b>	\$25.00 Copayment

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***Pharmacy Benefits Summary***

**Types of Coverage**

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<b>Prescription Drugs:</b>	<b>You Pay:</b>
<b>1. Tier 1</b>	\$10.00 Copayment per 31- day supply for retail
<b>2. Tier 2</b>	\$20.00 Copayment per 31- day supply for retail
<b>3. Tier 3</b>	\$35.00 Copayment per 31-day supply for retail
<b>4. Injectables</b>	With the exception of insulin and injectable contraceptive drugs, there is a 20% Copayment of pharmacy contract rate up to \$50.00 for injectables.
<b>5. Mail Order</b>	One (1) Copayment per 31 day consecutive supply for retail drugs and three (3) Copayments per 90 day supply for mail order drugs. Oral contraceptives at three (3) Copayments for three-cycle supply.
<b>6. Ancillary</b>	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.

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Pharmacy Rider Package: KH  
Prescription Drug Rider Form Number: 0143149-1005MD