


MAMSI Life and Health
Insurance Company
A UnitedHealthcare® Company

Benefits Summary
Preferred Provider Organization (PPO) Plan
Limited Benefit Plan
MD07PCS*RDMB

The MAMSI Life and Health Insurance Company (MLH) PPO plan provides you with medical coverage through a network of preferred physicians and other health care practitioners. No referrals are needed. You may also access services from non-preferred physicians and other health care practitioners; however, your Out-Of-Pocket cost may be higher if you do so.

Some of the Important Benefits of the PPO Plan:

- You have access to a network of preferred providers, including hospitals and specialists. Look on our Web site, www.mamsiUnitedHealthcare.com, to see our network of preferred providers.
- Benefits include coverage for the 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

Corporate Headquarters:
4 Taft Court
Rockville, MD 20850
www.mamsiUnitedHealthcare.com



A UnitedHealthcare® Company
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 description of your benefits and the terms under which your benefits are provided are contained in the Group Certificate that you will receive upon enrolling in the Plan.**
- If this Benefit Summary conflicts in any way with your Group Certificate, the Group Certificate shall prevail.
- Terms that are capitalized in the Benefit Summary are defined in the Group Certificate.
- All exclusions and limitations applicable to this Plan are described in your Group Certificate, and any riders and endorsements.
- **Annual Deductible:** No Deductible.
- **Out-of-Pocket Maximum:** No Out-of-Pocket Maximum

Types of Benefits	Preferred Option (Plan Pays)	Non-Preferred Option (Plan Pays)
1. Chiropractic Visits¹	100% up to a Maximum of \$200.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
2. Diagnostic Lab Tests	100% up to a Maximum of \$150.00 per Member per Contract Year.	100% Services Subject to limit stated under Preferred Provider Option.
3. Emergency Room Visits	100% up to a Maximum of \$200.00 per Member per Contract Year.	100% Services Subject to limit stated under Preferred Provider Option.
4. Eye Refraction Exam²	100% up to a Maximum of \$150.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
5. Hospital-Inpatient Stay³	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 100% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services.	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 50% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services. Services Subject to limit stated under Preferred Provider Option.
6. Infertility Services	Not a Covered Benefit.	Not a Covered Benefit.
7. Mammography Examinations²	100% up to a Maximum of \$150.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
8. Maternity Care¹	100% up to a Maximum of \$200.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
9. Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse – Inpatient³	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 100% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services.	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 50% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services. Services Subject to limit stated under Preferred Provider Option.

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Rider Package: MD07PCS*RDDB (PPO*RD + MD)
Group Certification Form Number: 0726306-0605MD

10. Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse –Outpatient	100% up to a Maximum of \$500.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
11. Orthopedic Devices⁴	100% up to a Maximum of \$250.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
12. Outpatient Hospital Services	The Member shall be responsible for 100% of the negotiated rate between the Company and a Preferred Provider.	Not a Covered Benefit.
13. Outpatient Hospital Surgeries	70% of Facility Charges up to a \$10,000 Maximum per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
14. Physician Services⁵	100% up to a Maximum of \$150.00 per Member per Contract Year for Preventive Services and \$200.00 total Maximum per Member per Contract Year for all other Physician Services.	50% Services Subject to limit stated under Preferred Provider Option.
15. Skilled Nursing Facility³	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 100% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services.	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 50% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services. Services Subject to limit stated under Preferred Provider Option.
16. Speech, Occupational and Physical Therapy¹	100% up to a Maximum of \$200.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
17. Well Child Care²	100% up to a Maximum of \$150.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
18. X-rays	100% up to a Maximum of \$150.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.

Additional Benefits:	Preferred Option (Plan Pays)	Non-Preferred Option (Plan Pays)
Durable Medical Equipment⁴	100% up to a Maximum of \$250.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
Family Planning Services¹	100% up to a Maximum of \$200.00 per Member per Contract.	50% Services Subject to limit stated under Preferred Provider Option.
Habilitative Services for Children Under the Age of 19¹	100% up to a Maximum of \$200.00 per Member per Contract.	50% Services Subject to limit stated under Preferred Provider Option.
Hearing Aid for Children Under the Age of 19	Subject to same Coinsurance as Durable Medical Equipment. For hearing aids for person up to 18 years old every 36 months.	Subject to same Coinsurance as Durable Medical Equipment. For hearing aids for person up to 18 years old every 36 months.
Home Health Care³	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 100% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services.	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 50% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services. Services Subject to limit stated under Preferred Provider Option.

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Hospice Services³	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 100% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services.	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 50% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services. Services Subject to limit stated under Preferred Provider Option.
Medication Management office visits associated with Mental Health or Substance Abuse¹	100% up to a Maximum of \$200.00 per Member per Contract Year.	50% Services Subject to limit stated under Preferred Provider Option.
Transplants³	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 100% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services for transplants of autologous and nonautologous bone marrow, cornea, kidney, liver heart, lung, heart/lung, pancreas, and pancreas/kidney.	100% up to \$1,000 per day for a Maximum of 30 days per Member per Contract Year for Facility Services. 50% up to a \$700.00 total Maximum per Member per Contract Year for Inpatient Physician and other Non-Facility Services. Services Subject to limit stated under Preferred Provider Option for transplants of autologous and nonautologous bone marrow, cornea, kidney, liver heart, lung, heart/lung, pancreas, and pancreas/kidney.

¹ Limits for these services are combined with all other Physician Non-Preventive services covered under the Group Certificate.

² Limits for these services are combined with all other Physician Preventive services covered under the Group Certificate.

³ Limits for these services are combined with other Inpatient Facility/Institutional and Inpatient Physician/Non-Facility services covered under the Group Certificate.

⁴ Limits for these services are combined with all other Equipment and Supplies covered under the Group Certificate.

⁵ Limits for these services are combined with all other Physician Preventive and Non-Preventive services covered under the Group Certificate.

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Pharmacy Benefits Summary
Preferred Provider Organization

Types of Coverage

Prescription Drugs	Preferred Option	Non Preferred Option
Tier 1	\$10.00 Copayment	Same as in Plan
Tier 2	\$30.00 Copayment	Same as in Plan
Tier 3	\$50.00 Copayment	Same as in Plan
Ancillary	\$250.00 Benefit Maximum for Individual Coverage. \$750.00 Benefit Maximum for Non-Individual Coverage.	
Deductibles	No Annual Deductible	

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Pharmacy Rider Package: RD
 Prescription Drug Form Number: 0726306-0605MD