

  
**MAMSI** Life and Health  
Insurance Company  
**A UnitedHealthcare® Company**

**Benefits Summary**  
**Preferred Provider Organization (PPO) Plan**  
**Base Plan**  
**MD07PPS\*FNMD**

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:***

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- You have access to a network of preferred providers, including hospitals and specialists. Look on our Web site, [www.mamsiUnitedHealthcare.com](http://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](http://www.mamsiUnitedHealthcare.com)


  
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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 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:** Preferred Option \$2,500 Single, \$5,000 Family. Non-Preferred Provider Option \$2,500 Single \$5,000 Family.
- **Out-of-Pocket Maximum:** \$4,900 per Member not to exceed \$9,800 per Family per Contract Year. Copayments for some Covered Services may not apply to the Out-of-Pocket Maximum as specified in the Group Certificate.

Types of Benefits	Preferred Option (Plan Pays)	Non-Preferred Option (Plan Pays)
1. <b>Chiropractic Visits</b>	70% Maximum of 20 visits per Condition per Contract Year.	50% Services count toward the limits stated under Preferred Provider Option.
2. <b>Diagnostic Lab Tests</b>	100% after \$40.00 Copayment or 80%, whichever is less, but not greater than the actual charge.	100% after \$40.00 Copayment or 60%, whichever is less, but not greater than the actual charge.
3. <b>Emergency Room Visits</b>	80% after \$100.00 Copayment, which shall be waived in the event Member is immediately admitted at which time the Inpatient Hospital Copayment of charges will apply.	80% after \$100.00 Copayment Per admission, when Medically Necessary.
4. <b>Eye Refraction Exam</b>	100% after \$40.00 Copayment or 80%, whichever is less, but not greater than the actual charge.	100% after \$40.00 Copayment or 60%, whichever is less, but not greater than the actual charge.
5. <b>Hospital-Inpatient Stay</b>	80% Requires Preadmission Authorization for Non-Emergency Admissions.	60% Requires Preadmission Authorization for Non-Emergency Admissions.
6. <b>Infertility Services</b>	50% Refer to contract for covered services.	50% Refer to contract for covered services.
7. <b>Mammography Examinations</b>	100% after \$40.00 Copayment or 80%, whichever is less, but not greater than the actual charges at the following interval: One (1) visit every other year for women ages 40-49; One (1) visit every year for women 50 years of age and older.	100% after \$40.00 Copayment or 60%, whichever is less, but not greater than the actual charges at the following interval: One (1) visit every other year for women ages 40-49; One (1) visit every year for women 50 years of age and older.

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Rider Package: MD07PPS\*--MD  
 Group Certification Form Number: 0726183-0799MD

8. Maternity Care	100% after \$40.00 Copayment or 80%, whichever is less, but not greater than the actual charge.	100% after \$40.00 Copayment or 60%, whichever is less, but not greater than the actual charge.
9. Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse – Inpatient	80% up to a maximum of 60 days per Member per Contract Year. Member not required to seek a treatment plan from a Preferred Psychiatrist.	60% Services count toward limits stated under Preferred Provider Option. Requires Preadmission Authorization for Non-Emergency Admissions.
10. Mental Illness, Emotional Disorder, Drug Abuse, and Alcohol Abuse – Outpatient	70% Member not required to seek a treatment plan from a Preferred Psychiatrist.	50%
11. Physician Services	100% after \$40.00 Copayment or 80%, whichever is less, but not greater than the actual charge.	100% after \$40.00 Copayment or 60%, whichever is less, but not greater than the actual charge.
12. Skilled Nursing Facility	100% after \$40.00 Copayment or 80%, whichever is less, but not greater than the actual charge up to 100 days per Member per Contract Year.	100% after \$40.00 Copayment or 60%, whichever is less, but not greater than the actual charge. Services count toward limit stated under Preferred Provider Option.
13. Speech, Occupational and Physical Therapy	70% up to a Maximum of 30 visits per Condition per Contract Year for Physical Therapy; Up to a Maximum of 30 visits per Condition per Contract Year for Speech Therapy; and Up to a Maximum of 30 visits per Condition per Contract Year for Occupational Therapy.	50% up to a Maximum of 30 visits per Condition per Contract Year for Physical Therapy; Up to a Maximum of 30 visits per Condition per Contract Year for Speech Therapy; and Up to a Maximum of 30 visits per Condition per Contract Year for Occupational Therapy Services count toward limit stated under Preferred Provider Option.
14. Urgent Care Services	80%	60%
15. Well Child Visits	100% after \$10.00 Copayment. Deductible does not apply.	60% Deductible does not apply.
16. X-rays	100% after \$40.00 Copayment or 80%, whichever is less, but not greater than the actual charge.	100% after \$40.00 Copayment or 60%, whichever is less, but not greater than the actual charge.
<b>Additional Benefits:</b>	<b>Preferred Option (Plan Pays)</b>	<b>Non-Preferred Option (Plan Pays)</b>
Family Planning Services	100% after \$40.00 Copayment or 80%, whichever is less, but not greater than the actual charge.	100% after \$40.00 Copayment or 60%, whichever is less, but not greater than the actual charge.
Habilitative Services for Children Under the Age of 19	100% after Applicable Copayment for Occupational Therapy, Physical Therapy, and Speech Therapy for the treatment of Child with a Congenital or Genetic Birth Defect to enhance the Child's ability to function. Except for Habilitative Services provided in Early Intervention or School Services.	100% after applicable Copayment. Same criteria as Preferred Provider Option.
Home Health Care	80%	60%
Hospice Services	80%	60%
Medication Management office	100% after \$40.00 Copayment or 80%	100% after \$40.00 Copayment or 60%

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<b>visits associated with Mental Health or Substance Abuse</b>	whichever is less, but not greater than the actual charge.	whichever is less, but not greater than the actual charge.
<b>Orthopedic Braces</b>	80% Requires Precertification.	60% Requires Precertification.
<b>Out of Pocket Maximum</b>	\$4,900 per Member not to exceed \$9,800 per Family per Contract Year	\$4,900 per Member not to exceed \$9,800 per Family per Contract Year
<b>Partial Hospitalization for Mental Health Care/Substance Abuse</b>	80% for Partial Hospitalization Services received in a Hospital or related Institution. Two Partial Hospitalization days may be substituted for one (1) Inpatient day.	60% Same criteria as Preferred Provider Option.
<b>Transplants</b>	80% for transplants of autologous and nonautologous bone marrow, cornea, kidney, pancreas/kidney, liver, heart, lung, heart/lung, pancreas when deemed to be Medically Necessary by the Plan. Requires Preadmission Authorization and Precertification.	60% for transplants of autologous and nonautologous bone marrow, cornea, kidney, pancreas/kidney, liver, heart, lung, heart/lung, pancreas when deemed to be Medically Necessary by the Plan. Requires Preadmission Authorization and Precertification. Same criteria as Preferred Provider Option.

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*Pharmacy Benefits Summary  
Preferred Provider Organization*

**Types of Coverage**

Prescription Drugs	Preferred Option	Non Preferred Option
<b>1. Deductible</b>	Member meets a \$2,500 Deductible if Member has individual coverage, or a \$5,000 Deductible if Member has family coverage. Once Deductible is met, Member pays a 75% Coinsurance for Prescription Drugs.	Same as Preferred Provider Option

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Pharmacy Rider Package: FN  
Prescription Drug Form Number: 07382670-0706MD