


A UnitedHealthcare® Company

Benefits Summary
Preferred Provider Organization (PPO) Plan
VA07P00*KQTC

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


MAMSI Life and Health
 Insurance Company
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:** Preferred Option \$500 Single; Non-Preferred Option \$1,000 Single \$2,000 Family.
- **Out-of-Pocket Maximum:** \$4,000 per Covered Member but not more than \$8,000 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. Acupuncture	80% up to 12 visits per Member per Contract Year and covered only for postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, postoperative dental pain and as a part of a comprehensive treatment program for chronic pain.	60% up to 12 visits per Member per Contract Year and covered only for postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, postoperative dental pain and as a part of a comprehensive treatment program for chronic pain. Services count toward limit stated under Preferred Provider Option.
2. Bilateral Vasectomy Services	80% Not Subject to Annual Deductible.	60% Not Subject to Annual Deductible.
3. Chiropractic Services	50% up to \$500.00 per Member per Contract Year.	50% up to \$500.00 per Member per Contract Year; Services count toward limit stated under Preferred Provider Option.
4. Diagnostic Lab Tests	80%	60%
5. Emergency Room Visits	80% if Medical Emergency or 50% if not a Medical Emergency. Not Subject to Annual Deductible if a Medical Emergency.	80% if a Medical Emergency or 50% if not a Medical Emergency. Not Subject to Annual Deductible if a Medical Emergency.
6. Eye Refraction Exam	100% after \$20.00 Copayment.	60%
7. Hospital-Inpatient Stay	80% Requires Preadmission	60% Requires Preadmission

*Preferred providers have agreed to accept the company's payment plus your applicable Deductible, Copayment, or Coinsurance as full payment for the claim. If you choose a Non-Preferred provider, the Company is responsible for paying the applicable percentage of the Requested Charge or Allowable Charges, whichever is less. You will be responsible for any applicable Deductible and Coinsurance plus the balance, if any, of the Non-Preferred provider's charges (Generally, your expense will be lower if you use a Preferred Provider rather than a Non-Preferred Provider). Certain Outpatient Procedures Require Precertification.
 This benefit level does not apply to Non-Preferred hospital-based providers

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Rider Package: VA07P00*--TC
 Group Certification Form Number: 0726212-0101VA

	Authorization for Non-Emergency Admissions.	Authorization for Non-Emergency Admissions.
8. Mammography Examinations	80% In accordance with the intervals set forth in the Contract. Not Subject to Annual Deductible.	60% Same criteria as Preferred Provider Option. Not Subject to Annual Deductible.
9. Maternity Care	80%	60%
10. Outpatient Surgeries and Services in a Hospital or Free Standing Surgical Facility	80%	60%
11. Physician Services	100% after \$20.00 Copayment for Primary Care Physician for Family, Practice, Internal Medicine, General Practice. Primary Care Services Not Subject to Annual Deductible. 80% for all other services.	60%
12. Mental Health Care/Substance Abuse-Inpatient	80% up to 30 combined days per Member per Contract Year. Requires Preadmission Authorization for non-emergency Admissions.	60% Services count toward limit stated under Preferred Provider Options. Requires Preadmission Authorization for Non-Emergency Admissions.
13. Mental Health Care/Substance Abuse-Outpatient	80% for visits 1-5; 50% for visits 6-20 per Member per Contract Year.	60% for visits 1-5; 50% for visits 6-20. Services count toward limit stated under Preferred Provider Option.
14. Skilled Nursing Facility	80% up to 60 days per Member per Contract Year provided such services are not Custodial Care. Requires Preadmission Authorization.	60% Same criteria as Preferred Provider Option. Services count toward limit stated under Preferred Provider Option. Requires Preadmission Authorization.
15. Speech, Occupational and Physical Therapy	80% up to 60 combined visits or 60 days per Condition of combined therapy types. Early Intervention Services limited to \$5,000 per Member per Contract Year.	60% Same Criteria as Preferred Provider Option. Services count toward limit stated under Preferred Provider Option.
16. Tubal Ligation Services	80% Not Subject to Annual Deductible.	60% Not Subject to Annual Deductible.
17. Urgent Care Services	80% Not Subject to Annual Deductible.	60% Not Subject to Annual Deductible.
18. Well Child Care	100% after \$20.00 Copayment for Primary Care Physician for Family, Practice, Internal Medicine, General Practice - Not Subject to Annual Deductible. 80% for Non-Primary Care Services.	60%
19. X-rays	80%	60%

Additional Benefits:	*Preferred Option (Plan Pays)	*Non-Preferred Option (Plan Pays)
Ambulance Service	80% when Medically Necessary. Not	60% when Medically Necessary. Not

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	Subject to Annual Deductible.	Subject to Annual Deductible.
Biologically Based Mental Illness/Substance Abuse Inpatient	80% Requires Preadmission Authorization.	60%
Biologically Based Mental Illness/Substance Abuse Outpatient	80% for Office Visit; 80% for Outpatient Services. Requires Preadmission Authorization.	60%
Circumcision	80%	60%
Durable Medical Equipment	50% Requires Precertification.	50%
Home Health Care	80% Requires Precertification.	60%
Hospice Services	80%	60%
Lifetime Maximum	\$1,000,000	\$1,000,000
Norplant Services	80%	60%
Partial Hospitalization	80% for inpatient/outpatient services. Requires Precertification.	60% Same criteria as Preferred Provider Option.
Prosthetic Devices	50% Requires Precertification.	50%
Transplants	80% Heart, heart/lung, lung, liver, pancreas, kidney, cornea, and all non-experimental bone marrow transplants. Requires Preadmission Authorization and Precertification. Member must meet certain criteria set forth in the Group Policy.	60% 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
1. Tier 1	\$10.00 Copayment	80%
2. Tier 2	\$20.00 Copayment	80%
3. Tier 3	\$35.00 Copayment	80%
4. Injectables	With the exception of insulin and injectable contraceptive drugs, there is a 20% Copayment of pharmacy contract rate up to \$50.00 for injectables.	With the exception of insulin and injectable contraceptive drugs, there is a 20% Copayment of pharmacy contract rate up to \$50.00 for injectables
5. Mail Order	One (1) Copayment per 31 day consecutive supply for retail drugs and two (2) Copayments per 90 day supply for mail order drugs. Oral contraceptives at three (3) Copayments for three-cycle supply for retail purchase and two (2) Copayments for three-cycle supply for mail order purchases.	One (1) Copayment per 31 day consecutive supply for retail drugs and two (2) Copayments per 90 day supply for mail order drugs. Oral contraceptives at three (3) Copayments for three-cycle supply for retail purchase and two (2) Copayments for three-cycle supply for mail order purchases.
6. Ancillary	Member must pay the difference between the cost of a Tier 3 or Tier 2 medication and a Tier 1 equivalent after payment of the appropriate Copayment. 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.	Member must pay the difference between the cost of a Tier 3 or Tier 2 medication and a Tier 1 equivalent after payment of the appropriate Copayment. 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.
7. Deductible	No Annual Deductible	No Annual Deductible

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Pharmacy Rider Package: KQ
 Prescription Drug Form Number: 0443135-0205VA