PPO Benefit Summary

Plan DPW06400

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE	$500 per individual/$1,000 per family	$1,000 per individual/$2,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$1,500 per individual/$3,000 per family	$3,000 per individual/$6,000 per family
LIFETIME MAXIMUM BENEFIT	Unlimited	
	AMOUNT COVERED	**AMOUNT COVERED**
PREVENTIVE HEALTH SERVICES ***See Preventive Services Card***		
Including, but not limited to:		
Routine physical exam	100%, deductible waived	Not covered
Well baby and well child care	100%, deductible waived	Not covered
Immunizations	100%, deductible waived	Not covered
Routine eye exam – *limit 1 exam per CY*	100%, deductible waived	Not covered
Preventive care outside physician's office	100%, deductible waived	Not covered
Nutritional counseling – *limit 3 sessions per CY*	100%, deductible waived	Not covered
Tobacco cessation program	100%, deductible waived	Not covered
PHYSICIAN OFFICE VISITS		
Office visits for illness or injury	100% after $30/visit, deductible waived	60% of Eligible Expenses (EE) after deductible
Injections/infusions	100%, deductible waived	60% of EE after deductible
INPATIENT HOSPITAL		
Unlimited days in a semi-private room	80% after deductible	60% of EE after deductible
Special care units	80% after deductible	60% of EE after deductible
Necessary ancillary hospital services	80% after deductible	60% of EE after deductible
Surgery and related services	80% after deductible	60% of EE after deductible
Anesthesia and its administration	80% after deductible	60% of EE after deductible
Transplant services (at designated facilities)	80% after deductible	Not covered
Maternity care (hospital services)	80% after deductible	60% of EE after deductible
Physician services including consultation	80% after deductible	60% of EE after deductible
OUTPATIENT HOSPITAL		
Surgery and related services	80% after deductible	60% of EE after deductible
Diagnostic X-ray and laboratory	80% after deductible	60% of EE after deductible
CT scans, PET scans, MRA, MRI and nuclear medicine	80% after deductible	60% of EE after deductible
EMERGENCY/URGENT CARE		
At hospital emergency department	100% after $150/visit, deductible waived	Same as Network benefit
	Copayment waived if admitted for an inpatient stay	
At urgent care facility (after-hour services)	100% after $30/visit, deductible waived	Same as Network benefit
At non-network physician's office	100% after $30/visit, deductible waived	Same as Network benefit
BEHAVIORAL HEALTH SERVICES		
Inpatient treatment (including detoxification)	80% after deductible	60% of EE after deductible
Residential treatment for substance use disorders	80% after deductible	60% of EE after deductible
Intermediate treatment	80% after deductible	60% of EE after deductible
Outpatient therapy visits and testing	100% after $30/visit, deductible waived	60% of EE after deductible
All other outpatient items and services	100%, deductible waived	60% of EE after deductible

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TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
	AMOUNT COVERED	AMOUNT COVERED
OTHER COVERED HEALTH SERVICES		
Home health care services	80% after deductible	60% of EE after deductible
	Combined network and non-network limit of 60 visits per calendar year	
Skilled nursing facility services	80% after deductible	60% of EE after deductible
	Combined network and non-network limit of 100 days per calendar year	
Hospice care	80% after deductible	60% of EE after deductible
Physician obstetrical services (prenatal, delivery and postnatal)	80% after deductible	60% of EE after deductible
Ambulance services	80% after deductible	60% of EE after deductible
Prosthetics	80% after deductible	60% of EE after deductible
Durable medical equipment	80% after deductible	60% of EE after deductible
Outpatient rehabilitation services	100% after $30/visit, deductible waived	60% of EE after deductible
	Combined network and non-network limit of 60 visits per calendar year for physical, speech, occupational and pulmonary; combined network and non-network limit of 36 visits per calendar year for Phase I and II cardiac rehabilitation	
Spinal treatment	100% after $20/visit, deductible waived *Limited to 36 visits per calendar year*	Not covered

Certain covered health services must be authorized in advance by PHP Insurance Company. The phone number to call to request authorization is on the member ID card.

Covered Health Services must be Medically Necessary as determined by PHP Insurance Company medical policy and nationally recognized guidelines.

Member materials, including the PPO Certificate of Coverage, can be found online at our Member Packet Portal. Members may use their member ID number to access benefit information on the Member Packet Portal through our web site at www.phpmm.org.

Except as may be specifically provided through a Rider to the policy, Exclusions include:

- Morbid obesity treatment
- Infertility treatment
- Vision care
- Prescription drugs
- Routine dental care
- Cosmetic surgery
- Experimental procedures
- Hearing aids
- Custodial care, bed care, convenience care, day care, domiciliary care

For additional information about Exclusions, contact This Summary of Benefits is intended only to highlight the Benefits provided under PHP Insurance Company and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to your Certificate of Coverage for a complete listing of covered services, limitations and Exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Policy issued to the Enrolling Group, the Policy will prevail. For answers to questions about information which appears in the summary, call our Customer Service Department at (517) 364-8456 or (800) 203-9519.

Important Notice on Patient Protection Provisions Included in Your Plan as Part of the Patient Protection and Affordable Care Act

You do not need authorization from us or from any other person in order to obtain access to obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology. However, the Network provider may be required to obtain authorization prior to certain services, which are listed in your Certificate of Coverage.

Your Plan covers Emergency Health Services in any hospital emergency department. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Health Services at a Non-Network facility. However, a Non-Network provider may send you a bill for any charges remaining after your Plan has paid.

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