PPO Benefit Summary

Plan DMP00900

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE	$200 per individual/$400 per family	$400 per individual/$800 per family
ANNUAL OUT-OF-POCKET MAXIMUM	None	$2,000 per individual/$4,000 per family
LIFETIME MAXIMUM POLICY	Unlimited	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 –*1 exam per CY*	100%, deductible waived	Not covered
Preventive care outside physician's office	100%, deductible waived	Not covered
Nutritional counseling – *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 $20/visit, deductible waived	80% of Eligible Expenses (EE) after deductible
Injections/infusions	100% after deductible	80% of EE after deductible
INPATIENT HOSPITAL		
Unlimited days in a semi-private room	100% after deductible	80% of EE after deductible
Special care units	100% after deductible	80% of EE after deductible
Necessary ancillary hospital services	100% after deductible	80% of EE after deductible
Surgery and related services	100% after deductible	80% of EE after deductible
Anesthesia and its administration	100% after deductible	80% of EE after deductible
Transplant services (at designated facilities)	100%, deductible waived *Limit of $1 million per transplant*	Not covered
Maternity care (hospital services)	100% after deductible	80% of EE after deductible
Physician services including consultation	100% after deductible	80% of EE after deductible
OUTPATIENT HOSPITAL		
Surgery and related services	100% after deductible	80% of EE after deductible
Diagnostic X-ray and laboratory	100% after deductible	80% of EE after deductible
CT scans, PET scans, MRA, MRI and Nuclear Medicine	100% after deductible	80% of EE after deductible
EMERGENCY/URGENT SERVICES		
At hospital emergency department	100% after $50/visit, deductible waived *Copay is waived if accidental injury or admitted for an inpatient stay*	Same as Network benefit
At urgent care facility (after hour services)	100% after $25/visit, deductible waived *Copay is waived if emergency or accidental injury*	80% of EE after deductible or 100% of EE, deductible waived if emergency or accidental injury
At physician's office if emergency or accidental injury	100%, deductible waived	Same as Network benefit
BEHAVIORAL HEALTH SERVICES		
Inpatient treatment (including detoxification)	100% after deductible	80% of EE after deductible
Residential treatment for substance use disorders	100% after deductible	80% of EE after deductible
Intermediate treatment	100% after deductible	80% of EE after deductible
Outpatient therapy visits and testing	100% after $20/visit, deductible waived	80% of EE after deductible
All other outpatient items and services	100%, deductible waived	80% of EE after deductible

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TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
	AMOUNT COVERED	AMOUNT COVERED
OTHER SERVICES		
Home health care	100% after deductible	Same as Network benefit
	Combined network and non-network limit of 60 visits per calendar year	
Skilled nursing facility/ inpatient rehabilitation facility	100% after deductible	Same as Network benefit
	Combined network and non-network limit of 120 days per calendar year	
Hospice care	100% after deductible	Same as Network benefit
Physician obstetrical services (prenatal, delivery and postnatal)	100% after deductible	80% of EE after deductible
Private duty nursing	90%, deductible waived	Same as Network benefit
Ambulance services	100% after deductible	Same as Network benefit
Prosthetic and orthotic devices	100% after deductible	Same as Network benefit
Durable medical equipment	100% after deductible	Same as Network benefit
Outpatient rehabilitation therapy	100% after deductible	80% of EE after deductible
	Combined network and non-network limit of 60 visits per calendar year	
Spinal treatment (chiropractic services and osteo-manipulation by D.O.)	100% after deductible	80% of EE after deductible
	Combined network and non-network limit of 38 visits per calendar year	
Hearing aids and services	100%, deductible waived	Same as Network benefit
	Combined network and non-network limit of $880 monaural or $1,600 for binaural; combined network and non-network limit of 1 each: hearing aid, exam, evaluation & testing during a 36-month period; must be referred by physician	

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
- 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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