

HMO PLUS Benefit Summary
MSPTA (T01)



Plan DPL06914

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE	None	\$200 per individual/\$400 per family
ANNUAL OUT-OF-POCKET MAXIMUM (includes medical deductible, copays, coinsurance)	\$3,000 per individual/\$6,000 per family	\$3,200 per individual/\$3,400 per family
PLAN YEAR	October 12, 2014 through October 9, 2015	
This Benefit plan does not contain an annual or lifetime limit on the dollar amount of Essential Health Benefits.		

	AMOUNT COVERED	AMOUNT COVERED
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PHYSICIAN OFFICE VISITS

Office visits for illness or injury	100% after \$10/visit	80% of Eligible Expenses (EE) after deductible
Injections/infusions	Covered 100%	80% of EE after deductible

PREVENTIVE SERVICES

Including but not limited to: <ul style="list-style-type: none"> Physical exams Well baby and well child care Immunizations Routine eye exam – <i>limit 1 exam per PY</i> Routine mammography 	Covered 100%	Not covered
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INPATIENT HOSPITAL

Unlimited days in a semi-private room, special care units, necessary ancillary hospital services, surgery and related services, anesthesia and its administration, physician services including consultation	Covered 100%	80% of EE after deductible
Transplant services (at designated facilities)	Covered 100%	Not covered

OUTPATIENT HOSPITAL

Surgery and related services	Covered 100%	80% of EE after deductible
Diagnostic X-ray and laboratory	Covered 100%	80% of EE after deductible
Diagnostic CT scans, PET scans, MRA, MRI and Nuclear Medicine	Covered 100%	80% of EE after deductible
Diagnostic services (such as certain endoscopic and cardiac procedures and therapeutic treatments)	Covered 100%	80% of EE after deductible

EMERGENCY/URGENT SERVICES

At hospital emergency department	100% after \$50/visit <i>Waived if admitted for an inpatient stay</i>	Same as Network benefit
At urgent care facility (after hour services)	100% after \$10/visit	Same as Network benefit
At non-network physician's office outside the service area	100% after \$10/visit	Same as Network benefit

BEHAVIORAL HEALTH SERVICES

Inpatient treatment (including detoxification)	Covered 100%	80% of EE after deductible
Residential treatment program	Covered 100%	80% of EE after deductible
Intermediate treatment	Covered 100%	80% of EE after deductible
Outpatient therapy visits and testing for mental health conditions	\$0/visit for first 20 visits in a PY. For each visit (21 or more) in a PY: \$10/visit	80% of EE after deductible
Outpatient therapy visits and testing for substance use disorders	Covered 100%	80% of EE after deductible
All other outpatient items and services (such as ECT)	Covered 100%	80% of EE after deductible

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	AMOUNT COVERED	AMOUNT COVERED
OTHER SERVICES		
Home health care	Covered 100% <i>Combined network and non-network benefits limited to 60 visits per PY</i>	80% of EE after deductible
Skilled nursing facility/ inpatient rehabilitation facility	Covered 100%	80% of EE after deductible <i>Limited to 100 days per CY</i>
Maternity care (prenatal, delivery and postnatal services)	Covered 100%	80% of EE after deductible
Hospice care	Covered 100%	80% of EE after deductible
Ambulance services	Covered 100%	Same as Network benefit
Prosthetic devices	Covered 100%	80% of EE after deductible
Durable medical equipment	Covered 100%	80% of EE after deductible
Outpatient rehabilitation therapy	100% after \$10/visit <i>Combined network and non-network limitations apply</i>	80% of EE after deductible
Infertility treatment	Covered 100% <i>Limited to 5 office visits and 3 diagnostic or surgical procedures per PY</i>	Not covered
Chiropractic services	100% after \$10/visit <i>Limited to 20 visits per PY</i>	Not covered
Nutritional counseling services	Covered 100% <i>Limited to 3 sessions per PY</i>	Not covered
Tobacco cessation program	Covered 100%	Not covered
Autism Spectrum Disorders treatment (for children from birth through age 18)	100% after \$10/visit <i>Limited to 930 hours per PY</i>	
Hearing aids	Covered 100% <i>Limited to either one monaural to a maximum benefit of \$880 or one binaural to a maximum of \$1600; every 36 months</i>	Not covered

Certain services must be authorized in advance to receive full coverage. Failure to obtain prior authorization when required may result in reduced or no benefit. Complete details are found in your PHP Certificate of Coverage. Covered Health Services must be Medically Necessary as determined by PHP medical policy and nationally recognized guidelines. Member materials, including the PHP Certificate of Coverage, can be found online at our Member Reference Desk. Members may access the Member Reference Desk through our web site at www.phpmichigan.com.

NOTE: This policy is not subject to a pre-existing condition limitation.

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

- Routine dental care
- Custodial care, bed care, convenience care, day care, domiciliary care
- Cosmetic surgery
- Experimental or investigational procedures or services
- Vision hardware

For additional information about exclusions and limitations, visit our web site, or contact the PHP Customer Service Department to review the PHP Certificate of Coverage for this benefit plan. This Summary of Benefits is intended only to highlight the benefits provided under HMO PLUS and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to the PHP 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 517.364.8500 or 800.832.9186.

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

If you wish to receive Network Benefits, you must select a Primary Care Physician from our list of participating providers who are available to accept you or your family members to coordinate your health care services. This helps ensure continuity of care and provides you and your Dependents with a medical home. If you are the custodial parent of an Enrolled Dependent child, you must select a Primary Care Physician for that child. Your child's PCP may be a Network pediatrician. You do not need authorization from us or from any other person (including a Primary Care Physician) 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.