HMO PLUS Benefit Summary

Physicians Health Plan
The Plan of Choice

Plan DPL12300

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE	None	$200 per individual/$400 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$3,000 per individual/$6,000 per family	$3,000 per individual/$3,000 per family
LIFETIME MAXIMUM POLICY	Unlimited	
	AMOUNT COVERED	**AMOUNT COVERED**
PHYSICIAN OFFICE VISITS		
Office visits for illness or injury	100% after $20/visit	80% of Eligible Expenses (EE) after deductible
Injections/infusions	100%	80% of EE after deductible
Maternity care (prenatal and postnatal services)	100%	80% of EE after deductible
PREVENTIVE SERVICES		
Including but not limited to: • Physical exams • Well baby and well child care • Immunizations • Routine eye exam – *limit 1 exam per CY* • Routine mammography	100%	Not covered
INPATIENT HOSPITAL		
Unlimited days in a semi-private room	100%	80% of EE after deductible
Special care units	100%	80% of EE after deductible
Necessary ancillary hospital services	100%	80% of EE after deductible
Surgery and related services	100%	80% of EE after deductible
Anesthesia and its administration	100%	80% of EE after deductible
Transplant services (at designated facilities)	100%	Not covered
Maternity care (hospital services)	100%	80% of EE after deductible
Physician services including consultation	100%	80% of EE after deductible
Physician obstetrical services (delivery)	100%	80% of EE after deductible
OUTPATIENT HOSPITAL		
Surgery and related services	100%	80% of EE after deductible
Diagnostic X-ray and laboratory	100%	80% of EE after deductible
CT scans, PET scans, MRA, MRI and Nuclear Medicine	100%	80% of EE after deductible
EMERGENCY/URGENT SERVICES		
At hospital emergency department	100% after $200/visit *Waived if admitted for an inpatient stay*	Same as Network benefit
At urgent care facility (after hour services)	100% after $20/visit	Same as Network benefit
At non-network physician's office outside the service area	100% after $20/visit	Same as Network benefit
BEHAVIORAL HEALTH SERVICES		
Inpatient/intermediate treatment (including detoxification)	100%	80% of EE after deductible
Residential treatment program for substance use disorders	100%	80% of EE after deductible
Outpatient therapy visits and testing for mental health conditions	$0/visit for first 20 visits in a calendar year. For each visit (21 or more) in a calendar year: $20/visit	80% of EE after deductible
Outpatient therapy visits and testing for substance use disorders	$0/visit for first 35 visits in a calendar year. For each visit (36 or more) in a calendar year: $20/visit	80% of EE after deductible
All other outpatient items and services (such as ECT)	100%	80% of EE after deductible

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	AMOUNT COVERED	AMOUNT COVERED
OTHER SERVICES		
Home health care	100%	80% of EE after deductible
	Combined network and non-network benefits limited to 60 visits per CY	
Skilled nursing facility/ inpatient rehabilitation facility	100%	80% of EE after deductible *Limited to 100 days per CY*
Hospice care	100%	80% of EE after deductible
Ambulance services	100%	Same as Network benefit
Prosthetic devices	100%	80% of EE after deductible
Durable medical equipment	100%	80% of EE after deductible
Outpatient rehabilitation therapy	100% after $20/visit	80% of EE after deductible
	Combined network and non-network limitations apply	
Infertility treatment	100% *Limited to $10,000 per CY*	Not covered
Chiropractic services	100% after $20/visit *Limited to 20 visits per CY*	Not covered
Nutritional counseling services	100% *Limited to 3 sessions per CY*	Not covered
Tobacco cessation program	100%	Not covered
Hearing aids	100% *Limited to either one monaural to a maximum benefit of $880 or one binaural to a maximum of $1600; every 36 months*	Not covered
Laser eye surgery	100% *Limited to $755 for both eyes per lifetime*	

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

Member materials, including the PHP 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:

- Routine dental care
- Cosmetic surgery
- Experimental procedures
- Prescription drugs
- Custodial care, bed care, convenience care, day care, domiciliary care
- Vision services

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 Patient Protection and 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. *8/11*

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on our Prescription Drug List at a Network Pharmacy and are subject to Copayments or Coinsurance amounts that vary depending on which of the tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please access www.medco.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

Retail Copayment		Mail-Order Service Copayment	
Tier-1 Prescription Drug Product	$10	Tier-1 Prescription Drug Product	$20
Tier-2 Prescription Drug Product	$30	Tier-2 Prescription Drug Product	$60
Tier-3 Prescription Drug Product	$60	Tier-3 Prescription Drug Product	$120

40% coinsurance for Prescription Drug Products for the treatment of infertility – Retail or Mail-Order Service.

50% coinsurance for Prescription Drug Products for the treatment of treatment of obesity for a Covered Person who qualifies under our current "Prescription Weight Loss Medication Policy" – Retail or Mail-Order Service.

0% coinsurance for Prescription Drug Products for growth hormone therapy – Retail or Mail-Order Service.

0% coinsurance for Preferred Tobacco Cessation Products – Retail Service only.

Supply Limits

- Retail: Up to 31 consecutive day supply

- Mail: Up to 90 consecutive day supply

Some products may have additional quantity limits.

Please consult with your physician. These specific quantity limits may be exceeded in certain situations at the request of your physician.

Mail-Order Service Convenience

Mail-Order Service Pharmacy allows you to have your prescriptions filled and delivered directly to your doorstep. You save on out-of-pocket costs too. Call our Customer Service Department for more information. Our phone number is listed on the back of your ID card.

Exclusions

Some of the exclusions that apply to your benefit are listed below. Please look at your pharmacy rider available on the Member Packet Portal at www.phpmm.org for a complete listing of exclusions.

- Experimental products
- Appetite suppressants and other weight loss products
- Over the counter drugs
- Replacement prescriptions
- Medications for cosmetic purposes only

Please contact the PHP Customer Service Department at the number listed on the back of your ID card if you have questions.