HMO Plus Benefit Summary

Plan BEC01700

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
	AMOUNT COVERED	AMOUNT COVERED
OTHER SERVICES		
Home health care	100% after deductible	80% of EE after deductible
	Combined network and non-network benefits limited to 60 visits per CY	
Skilled nursing facility/ inpatient rehabilitation facility	100% after deductible	80% of EE after deductible
	Combined network and non-network benefits limited to 100 days per CY	
Hospice care	100% after deductible	80% of EE after deductible
Ambulance services	100% after deductible	Same as Network benefit
Prosthetic devices	100% after deductible	80% of EE after deductible
Durable medical equipment	50% after deductible	50% of EE after deductible
Outpatient rehabilitation therapy	100% after $30/visit, deductible waived	80% of EE after deductible
	Combined network and non-network limitations apply	
Infertility treatment (to treat the conditions that result in infertility)	50% after deductible *Limited to $10,000 per CY*	Not covered
Chiropractic services	100% after $30/visit, deductible waived *Limited to 18 visits per CY*	Not covered
Nutritional counseling services	100%, deductible waived *Limited to 3 sessions per CY*	Not covered
Tobacco cessation program	100%, deductible waived	Not covered
Autism Spectrum Disorders treatment (for children from birth through age 18)	100% after $30/visit, deduductible waived *ABA limited to $50,000 per CY*	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 the HMO Plus Certificate of Coverage.

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

Member materials, including your 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.

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
- Cosmetic surgery
- Vision hardware
- Prescription drugs
- Custodial care, bed care, convenience care, day care, domiciliary care
- Hearing aids and services
- Experimental or investigational procedures or 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 the Policy and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to your 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. *1/13*

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Plan BEC01700

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE	$2,500 per individual/$5,000 per family	$5,000 per individual/$10,000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	$5,000 per individual/$10,000 per family	$10,000 per individual/$20,000 per family
LIFETIME MAXIMUM POLICY	Unlimited	Unlimited
	AMOUNT COVERED	**AMOUNT COVERED**
PHYSICIAN OFFICE VISITS		
Office visits for illness or injury	100% after $30/visit, deductible waived	80% of Eligible Expenses (EE) after deductible
Allergy injections	100% after $5 per visit, deductible waived	80% of EE after deductible
Other injections/infusions	100% after deductible	80% of EE after deductible
Maternity care (prenatal, delivery and postnatal services)	100%, deductible waived	80% of EE after deductible
PREVENTIVE SERVICES		
Including but not limited to: • Physical exams • Well baby & well child care • Immunizations • Routine eye exam – *limit of 1 exam per CY* • Routine mammography • Routine lab & x-ray	100%, deductible waived	Not covered
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% after deductible	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		
Surgical sterilization-female and related services	100%, deductible waived	80% of EE after deductible
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
Diagnostic advanced imaging and nuclear medicine	100% after deductible	80% of EE after deductible
EMERGENCY/URGENT SERVICES		
At hospital emergency department	100% after $150/visit, deductible waived *Copay waived if admitted as inpatient*	Same as network benefit
At urgent care facility (after hour services)	100% after $30/visit, deductible waived	Same as network benefit
At non-network physician's office outside the service area	100% after $30/visit, deductible waived	Same as network benefit
BEHAVIORAL HEALTH SERVICES		
Inpatient/intermediate/day treatment for mental health disorders	100% after deductible *Limited to 30 days per CY*	Not covered
Outpatient treatment for mental health disorders	100% after $30/visit, deductible waived *Combined network and non-network benefits limited 20 visits per CY*	80% of EE after deductible
Inpatient detoxification treatment	100% after deductible	80% of EE after deductible
Intermediate treatment for substance use disorders (including residential treatment programs)	100% after deductible *Maximums apply*	80% of EE after deductible
Outpatient treatment for substance use disorders	100% after $30/visit, deductible waived *Maximums apply*	80% of EE after deductible

DELTA DENTAL

Physicians Health Plan

The following chart indicates the services covered by Delta Dental of Michigan. **Please mark the plan of your choice.**	Delta Dental PPO℠ (Point-of-Service)						Delta Dental PPO℠ (Standard)	
	Plan AA ☑		Plan BB ☐		Plan CC ☐		Plan DD ☐	
Effective 1/1/2013 – 12/31/2013	PPO Dentist	Premier / Nonparticipating	PPO Dentist	Premier / Nonparticipating	PPO Dentist	Premier / Nonparticipating	Plan Pays	You Pay
Diagnostic and Preventive								
Diagnostic and Preventive Services – Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings, and fluoride treatments).	100%	100%	100%	100%	80%	50%	50%	50%
Emergency Palliative Treatment – Used to temporarily relieve pain.	100%	100%	100%	100%	80%	50%	50%	50%
Radiographs – X-rays.	100%	100%	100%	100%	80%	50%	50%	50%
Sealants – Dental sealants to prevent decay of permanent molars (to age 9 on first molars and age 14 on second molars).	100%	100%	100%	100%	80%	50%	50%	50%
Basic Services								
Oral Surgery Services – Extractions and dental surgery, including preoperative and postoperative care.	80%	80%	80%	80%	50%	50%	50%	50%
Minor Restorative Services – Used to repair teeth damaged by disease or injury (includes posterior composite resins).	80%	80%	80%	80%	50%	50%	50%	50%
Periodontics – Used to treat diseases of the gums and supporting structures of the teeth.	80%	80%	80%	80%	50%	50%	50%	50%
Endodontics – Used to treat teeth with diseased or damaged nerves (for example, root canals).	80%	80%	80%	80%	50%	50%	50%	50%
Major Services								
Prosthodontics – Used to replace missing natural teeth (for example, bridges and dentures).	50%	50%	50%	50%	50%	50%	50%	50%
Major Restorative Services – Used when teeth cannot be restored with another filling material (for example, crowns).	50%	50%	50%	50%	50%	50%	50%	50%
Implants – Used to replace missing natural teeth.	50%	50%	50%	50%	50%	50%	50%	50%
Orthodontic Services								
Orthodontic Services (to age 19) – Used to correct malposed teeth and/or facial bones (for example, braces).	50%	50%	0%	0%	0%	0%	0%	100%
Maximum Payment – The maximum payment per person, per calendar year on Diagnostic & Preventive, Basic Services, and Major Services is:	$1,000		$1,000		$1,000		$1,000	
The per lifetime maximum on Orthodontics is:	$1,000		$0		$0		$0	
Deductible – The per person/per family deductible on Basic and Major Services is: The deductible does not apply to Diagnostic & Preventive or Orthodontic Services.	50/150		50/150		$0		$0	
RATE PER SUBSCRIBER PER MONTH –								
Employee only	$40.52		$40.52		$25.71		$19.23	
Employee and one dependent	$76.60		$73.42		$46.64		$34.90	
Employee and two or more dependents	$144.57		$139.00		$77.09		$57.69	