Physicians Health Plan Plus

HIGH DEDUCTIBLE HEALTH PLAN

Benefit Summary LHP00700

Physicians
Health Plan[SM]
of Mid-Michigan

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
	The benefits below are covered when provided by Physicians Health Plan of Mid-Michigan Network providers.	The benefits below are covered when received through Non-Network providers. Some services require notification. If we are not notified when required, Benefits will be reduced or not covered. Refer to your Certificate of Coverage for notification requirements.
ANNUAL DEDUCTIBLE:	$1,250 Single $2,500 Family	$2,500 Single $5,000 Family
OUT-OF-POCKET MAXIMUM:	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family

If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, no one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied. The Annual Deductible and Out-of-Pocket Maximums are combined for medical and prescription drug benefits. There are separate accumulators for Network and Non-Network Annual Deductibles and Out-of-Pocket Maximums.

NOTE: *In the event that someone covered under the Policy moves from single coverage (only one individual covered) to family coverage (more than one individual in a family covered) or from family coverage to single coverage in the same calendar year, the deductible and out-of-pocket amount satisfied by each individual will follow them, and will be applied toward the Annual Deductible and/or Out-of-Pocket Maximums.*

For Example: An individual has single coverage, marries in the middle of the calendar year, and adds his/her spouse – the deductible and out-of-pocket amounts the individual satisfied while covered as a single individual, will be applied toward the family Annual Deductible and/or Out-of-Pocket Maximum amounts.

Similarly, if one individual of a two-person family terminates coverage, leaving the remaining family member with single coverage, any deductible and out-of-pocket amounts (to a maximum of the Single Annual Deductible and/or Out-of-Pocket Maximum amount) previously satisfied by that remaining individual will be applied toward the single Annual Deductible and/or Out-of-Pocket Maximum.

LIFETIME MAXIMUM:	Unlimited	Unlimited

TYPE OF BENEFITS	NETWORK BENEFITS AMOUNT COVERED	NON-NETWORK BENEFITS AMOUNT COVERED
PREVENTIVE HEALTH SERVICES		
Routine physical examinations, including: • related pathology and radiology services • Well baby and well child • Immunizations • Voluntary family planning • Hearing screening & routine eye exam • Routine screening mammography	100% deductible does not apply	Not available
Nutritional counseling	100% deductible does not apply	Not Covered
Tobacco Cessation program	100% deductible does not apply	Not Covered
PHYSICIAN OFFICE VISITS		
Office visits for illness or injury	100% after deductible	70% of Eligible Expenses (EE) after deductible
Maternity care (pre and postnatal services)	100% after deductible	70% of EE after deductible
Injections	100% after deductible	70% of EE after deductible

TYPE OF BENEFITS	NETWORK BENEFITS AMOUNT COVERED	NON-NETWORK BENEFITS AMOUNT COVERED
INPATIENT HOSPITAL		
Inpatient Hospital services include: • Unlimited days in a semi-private room • Special care units • Necessary ancillary hospital services • Surgery and related services • Anesthesia and its administration • Transplant Services (at designated facilities) • Maternity care (hospital services) • Physician services, including consultation • Physician obstetrical services	100% after deductible	70% of EE after deductible
OUTPATIENT HOSPITAL		
Surgery and related services	100% after deductible	70% of EE after deductible
Diagnostic X-ray and laboratory, CT scans, PET scans, MRI and Nuclear Medicine	100% after deductible	70% of EE after deductible
EMERGENCY CARE		
At hospital emergency Room	100% after deductible	Same as Network
At urgent care facility	100% after deductible	Same as Network
MENTAL HEALTH, ALCOHOLISM & SUBSTANCE ABUSE SERVICES		
Inpatient/Intermediate mental health	100%, after deductible Maximum of 30 days	Not Covered
Outpatient mental health Combined Network and Non-Network benefits limited to 20 visits per calendar year	100%, after deductible	70% of EE after deductible
Intermediate care services for alcoholism, substance abuse	100%after deductible (maximums apply)	70% of EE after deductible (maximums apply)
Outpatient services for alcoholism, substance abuse	100%after deductible (maximums apply)	70% of EE after deductible (maximums apply)
OTHER SERVICES		
Home health agency services Combined Network and Non-Network benefits limited to 60 visits per calendar year	100% after deductible	70% of EE after deductible
Skilled nursing facility services Combined Network and Non-Network benefits limited to 100 days per calendar year	100% after deductible	70% of EE after deductible
Hospice care	100% after deductible	70% of EE after deductible (limitations apply)
Ambulance services	100% after deductible	Same as Network
Prosthetics	100% after deductible (limitations apply)	70% of EE after deductible (limitations apply)
Durable medical equipment	100% after deductible (limitations apply)	70% of EE after deductible (limitations apply)

TYPE OF BENEFITS	NETWORK BENEFITS AMOUNT COVERED	NON-NETWORK BENEFITS AMOUNT COVERED
Outpatient rehabilitation services Combined Network and Non-Network limitations of 60 visits per calendar year for physical, speech, occupational and pulmonary; up to 36 visits per calendar year for cardiac rehabilitation.	100% after deductible	70% of EE after deductible
Infertility services	100% after deductible (maximums and limitations apply)	Not Covered
Chiropractic Services	100% after deductible (maximum of 18 visits)	Not Covered

NETWORK BENEFITS

All medical services (except preventive care as outlined above) are subject to an annual deductible.

Except in an emergency, medically necessary and preventive health care services must be provided, arranged or authorized through Physicians Health Plan of Mid-Michigan and its participating physicians to qualify for Network benefits. All referrals to non-PHPMM providers require prior plan approval.

All mental health, alcoholism and substance abuse services must be provided or authorized in advance by the plan's Mental Health/Substance Abuse Designee.

Member materials, including the PHPMM Certificate of Coverage, can be found online at our Member Packet Portal.

Members may access the Member Packet Portal through our web site at www.phpmm.org

NON-NETWORK BENEFITS

All medical services are subject to an annual deductible.

Only medically necessary services that are a result of an injury or sickness are covered.

In general, health services provided through a non-PHPMM provider require notification in advance.

Failure to provide prior notification when required may result in reduced benefits, and in some instances benefits may be denied. Without prior notification, benefits will be reduced to 50% except durable medical equipment and prosthetics which will be denied.

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

Exclusions include:

- Dental care
- Cosmetic surgery
- Experimental procedures
- Hearing aids
- Non-Network charges in excess of the Eligible Expenses as determined in accordance with our reimbursement policy guidelines
- Custodial care, bed care, convenience care, day care, domiciliary care

For additional information about exclusions, contact the PHPMM Customer Services Department or review the PHPMM Certificate of Coverage for this benefit plan.

This Summary of Benefits is intended only to highlight the benefits provided under PHP 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 Physicians Health Plan of Mid-Michigan (PHPMM) 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.

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