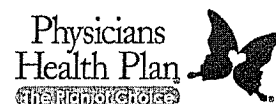


**PHP Select PLUS HDHP – MHP00800 BASE PLAN  
Benefit Summary**


TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS*
<b>ANNUAL DEDUCTIBLE:</b>	\$1250 Single \$2500 Family	\$2500 Single \$5000 Family
<b>ANNUAL OUT-OF-POCKET MAXIMUM:</b>	\$2500 Single \$5000 Family	\$5000 Single \$10000 Family
<b>NOTE:</b> If more than one person in a family is covered under the Policy, the single coverage Annual Deductible and single coverage Annual Out-of-Pocket Maximum do 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 Annual Out-of-Pocket Maximum are combined for medical and prescription drug benefits. There are separate accumulators for Network and Non-Network Annual Deductibles and Annual Out-of-Pocket Maximums.		
<b>LIFETIME POLICY MAXIMUM:</b>	Unlimited	

	AMOUNT COVERED	AMOUNT COVERED
<b>PREVENTIVE HEALTH SERVICES</b>		
Routine physical examinations, including: <ul style="list-style-type: none"> <li>• Related pathology and radiology services</li> <li>• Outpatient prenatal visits</li> <li>• Well baby and well child</li> <li>• Immunizations</li> <li>• Voluntary family planning</li> <li>• Hearing screening &amp; routine eye exam</li> <li>• Routine screening mammography</li> </ul>	100%, deductible waived	Not covered
Nutritional counseling	100%, deductible waived	Not covered
Tobacco cessation program (medications may have copay)	100%, deductible waived	Not covered
<b>PHYSICIAN OFFICE VISITS</b>		
Office visits for illness or injury	80% after deductible	60% of Eligible Expenses (EE) after deductible
Maternity care (delivery & postpartum services)	80% after deductible	60% of EE after deductible
Injections/infusions	80% after deductible	60% of EE after deductible
<b>INPATIENT HOSPITAL SERVICES</b>		
<ul style="list-style-type: none"> <li>• Unlimited days in a semi-private room</li> <li>• Special care units</li> <li>• Necessary ancillary hospital services</li> <li>• Surgery and related services</li> <li>• Anesthesia and its administration</li> <li>• Maternity care (hospital services)</li> <li>• Physician services, including consultation</li> <li>• Physician obstetrical services</li> </ul>	80% after deductible	60% of EE after deductible
<b>OUTPATIENT HOSPITAL SERVICES</b>		
Surgery and related services	80% after deductible	60% off EE after deductible
Diagnostic X-ray and laboratory, CT scans, PET scans, MRA, MRI & Nuclear Medicine	80% after deductible	60% off EE after deductible
<b>EMERGENCY/URGENT CARE</b>		
At hospital emergency department	80% after deductible	Same as Network benefit
At urgent care facility	80% after deductible	Same as Network benefit
At non-network physician's office outside the service area	80% after deductible	Same as Network benefit
<b>BEHAVIORAL HEALTH SERVICES**</b>		
Inpatient treatment (including detoxification)	80% after deductible	60% off EE after deductible
Outpatient/intermediate/day treatment	80% after deductible	60% off EE after deductible

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS*
	AMOUNT COVERED	AMOUNT COVERED
<b>OTHER SERVICES</b>		
Transplant services (at designated facilities)	80% after deductible	Not covered
Home health care	80% after deductible <i>Combined network and non-network limit of 60 visits per CY</i>	60% off EE after deductible
Skilled nursing facility/inpatient rehabilitation facility	80% after deductible <i>Combined network and non-network limit of 100 days per CY</i>	60% off EE after deductible
Hospice care	80% after deductible	60% off EE after deductible
Ambulance services	80% after deductible	Same as network benefit
Prosthetics	80% after deductible	60% off EE after deductible
Durable medical equipment	80% after deductible <i>Limitations apply</i>	60% off EE after deductible
Outpatient rehabilitation therapy	80% after deductible <i>Combined network and non-network maximums apply</i>	60% off EE after deductible
Infertility services	80% after deductible <i>Maximums and limitations apply</i>	Not covered
Chiropractic Services	80% after deductible <i>Maximum of 18 visits per CY</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 the PHP Select PLUS HDHP Certificate of Coverage.

\*\* All Behavioral Health Services must be provided or authorized in advance by the Plan's Behavioral Health Designee. The phone number is on the member ID card.

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

Exclusions include:

- Routine dental care
- Cosmetic surgery
- Experimental procedures
- Hearing aids
- Vision services
- 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

Covered services must be Medically Necessary as determined by PHPMM medical policy and nationally recognized guidelines.

Member materials, including the PHP Select PLUS HDHP Certificate of Coverage, can be found online at our Member Packet Portal. Members use their member ID number to access their benefits on the Member Packet Portal through our web site at [www.phpmm.org](http://www.phpmm.org).

This Summary of Benefits is intended only to highlight the benefits provided under this Plan 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 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.