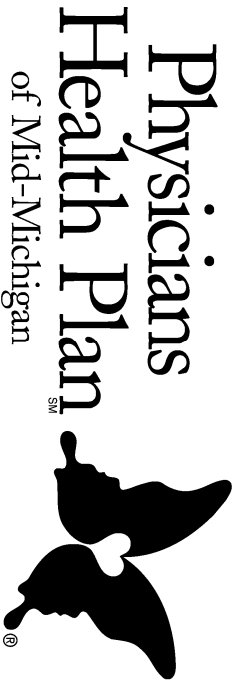


Physicians Health Plan Plus

Benefit Summary LPL06800



TYPE OF BENEFITS	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
	The benefits below are covered when provided by Physicians Health Plan of Mid-Michigan participating providers.	The benefits below are covered when received through non-participating 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	\$0 per person/\$0 per family	\$250 per person/\$500 per family per calendar year (CY)
LIFETIME MAXIMUM	Unlimited	Unlimited
	AMOUNT COVERED	AMOUNT COVERED

PHYSICIAN OFFICE VISITS

Office visits for illness or injury	All charges over \$20 per visit	80% of Eligible Expenses (EE) after deductible
Physical exams	All charges over \$20 per visit	Not covered
Well baby care	All charges over \$20 per visit	Not covered
Immunizations	100%	Not covered
Family planning; birth control devices; voluntary sterilization	All charges over \$20 per visit	Not covered
Vision exams	All charges over \$20 per visit per visit (limitations apply)	Not covered
Maternity care (pre and postnatal services)	100%	80% of EE after deductible
Injections Note: prior notification is required for certain injectables	100%	80% of EE after deductible

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	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, MRI and Nuclear Medicine	100%	80% of EE after deductible
Voluntary sterilization	100%	80% of EE after deductible Note: prior notification is not required for outpatient hospital services

TYPE OF BENEFITS	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
	AMOUNT COVERED	AMOUNT COVERED
EMERGENCY CARE		
At hospital emergency room	All charges over \$50 per visit <i>(waived if admitted for an inpatient stay)</i>	Covered as-network benefit
At urgent care facility (after-hour services)	All charges over \$25 per visit	Covered as network benefit
At non-network physician's office outside the service area	All charges over \$20 per visit	Covered as network benefit
MENTAL HEALTH, ALCOHOLISM & SUBSTANCE ABUSE SERVICES		
Inpatient/Intermediate mental health	30 days at 100%	Not covered
Outpatient mental health	All charges over no per visit <i>(combined network and non-network benefits limited to 20 visits per CY)</i>	80% of EE, deductible waived <i>(combined network and non-network benefits limited to 20 visits per CY)</i> Note: prior notification is not required for MH/SA services
Intermediate care services for alcoholism, substance abuse	100% <i>(maximums apply)</i>	80% of EE after deductible <i>(maximums apply)</i> Note: prior notification is not required for MH/SA services
Outpatient services for alcoholism, substance abuse	100% <i>(maximums apply)</i>	80% of EE after deductible <i>(maximums apply)</i> Note: prior notification is not required for MH/SA services
OTHER SERVICES		
Home health agency services	100% <i>(combined network and non-network benefits limited to 60 visits per CY)</i>	80% of EE after deductible <i>(combined network and non-network benefits limited to 60 visits perCY)</i>
Skilled nursing facility services	100% <i>(combined network and non-network benefits limited to 100 days per CY)</i>	80% of EE after deductible <i>(combined network and non-network benefits limited to 100 days per CY)</i>
Hospice care	100%	80% of EE after deductible <i>(Non-network limit of 180 days during the entire period of time covered under the Policy)</i>
Ambulance services	100%	Covered as network benefit
Prosthetics	80% after deductible <i>(limitations apply)</i>	80% of EE after deductible <i>(limitations apply)</i>
Durable medical equipment	80% after deductible <i>(limitations apply)</i>	80% of EE after deductible <i>(limitations apply)</i>
Outpatient rehabilitation services	100% <i>(combined network and non-network limitations apply)</i>	80% of EE after deductible <i>(combined network and non-network limitations apply)</i>
Infertility services	60% <i>(maximums apply)</i>	Not covered
Chiropractic services	All charges over \$20 per visit <i>(limited to 18 visits per CY)</i>	Not covered

IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
<p>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 in-network benefits. All referrals to non-PHPMM providers require prior plan approval.</p> <p>All mental health, alcoholism and substance abuse services must be provided or authorized in advance by the plan's Mental Health/Substance Abuse Designee.</p> <p>Maximum copayments for all health services per calendar year: \$1000 per covered person (not to exceed \$2000 per family). Copayments charged as a flat dollar amount (instead of as a percentage of eligible expenses) do not apply to this maximum. The out-of-pocket maximum does not include the annual deductible.</p>	<p>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 must be authorized 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.</p> <p>All medical services are subject to an annual deductible. The annual deductible is \$250 per covered person not to exceed \$500 per family every calendar year. After the deductible has been satisfied, eligible expenses are covered at the percentages indicated.</p> <p>Under this coverage your maximum out-of-pocket expense is limited to \$2000 per person, or \$4000 per family, per calendar year. The out-of-pocket maximum does not include the annual deductible.</p>

Member materials, including the PHPMM PHP Plus 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

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:

- Dental care
- Cosmetic surgery
- Experimental procedures
- Hearing aids
- Prescription drugs
- 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 PHP Plus 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) PHP Plus 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.

09/06