

PHP Select PLUS HMO – MPL12100 LOW PLAN
HMO/PLUS Benefit Summary



TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS*
ANNUAL DEDUCTIBLE	\$500 per individual/\$1000 per family	\$1000 per individual/\$2000 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$1500 per individual/\$3000 per family	\$3000 per individual/\$6000 per family
LIFETIME MAXIMUM POLICY	Unlimited	Unlimited
	AMOUNT COVERED	AMOUNT COVERED

PHYSICIAN OFFICE VISITS

Office visits for illness or injury	100% after \$20/visit, deductible waived	70% of Eligible Expenses (EE) after deductible
Physical exams, well baby care	100% after \$20/visit, deductible waived	Not covered
Immunizations	100%, deductible waived	Not covered
Family planning; birth control devices; voluntary sterilization	100% after \$20/visit, deductible waived	Not covered
Routine eye exam	100% after \$20/visit, deductible waived	Not covered
Maternity care (pre and postnatal services)	100%, deductible waived	70% of EE after deductible
Injections/infusions	100%, deductible waived	70% of EE after deductible

INPATIENT HOSPITAL

Unlimited days in a semi-private room	80% after deductible	70% of EE after deductible
Special care units	80% after deductible	70% of EE after deductible
Necessary ancillary hospital services	80% after deductible	70% of EE after deductible
Surgery and related services	80% after deductible	70% of EE after deductible
Anesthesia and its administration	80% after deductible	70% of EE after deductible
Transplant services (at designated facilities)	80% after deductible	Not covered
Maternity care (hospital services)	80% after deductible	70% of EE after deductible
Physician services including consultation	80% after deductible	70% of EE after deductible
Physician obstetrical services	100%, deductible waived	70% of EE after deductible

OUTPATIENT HOSPITAL

Surgery and related services	80% after deductible	70% of EE after deductible
Diagnostic X-ray and laboratory	100%, deductible waived	70% of EE after deductible
CT scans, PET scans, MRA, MRI and Nuclear Medicine	80% after deductible	70% of EE after deductible

EMERGENCY/URGENT SERVICES

At hospital emergency department	100% after \$100/visit, deductible waived Copayment waived if admitted for an inpatient stay	Same as Network benefit
At urgent care facility (after hour services)	100% after \$50/visit, deductible waived	Same as Network benefit
At non-network physician's office outside the service area	100% after \$20/visit, deductible waived	Same as Network benefit

BEHAVIORAL HEALTH SERVICES**

Inpatient treatment (including detoxification)	80% after deductible	70% of EE after deductible
Outpatient/intermediate/day treatment	100% after \$20/visit, deductible waived	70% of EE after deductible

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS*
	AMOUNT COVERED	AMOUNT COVERED
OTHER SERVICES		
Home health care	80% after deductible <i>Combined network and non-network benefits limited to 60 visits per CY</i>	70% of EE after deductible
Skilled nursing facility/ inpatient rehabilitation facility	80% after deductible <i>Combined network and non-network benefits limited to 100 days per CY</i>	70% of EE after deductible
Hospice care	100%, deductible waived	70% of EE after deductible
Ambulance services	80% after deductible	Same as Network benefit
Prosthetic devices	80% after deductible <i>Limitations apply</i>	70% of EE after deductible
Durable medical equipment	80% after deductible <i>Limitations apply</i>	70% of EE after deductible
Outpatient rehabilitation therapy	100% after \$20/visit, deductible waived <i>Combined network and non-network limitations apply</i>	70% of EE after deductible
Infertility treatment	50% after deductible <i>(maximums apply)</i>	Not covered
Chiropractic	100% after \$20/visit, deductible waived <i>Limited to 18 visits per CY</i>	Not covered
Nutritional counseling services	100% after \$20/visit, deductible waived	Not covered
Tobacco cessation program	Please call the Customer Service Department for details on this benefit.	

* Certain services must be authorized in advance to receive full coverage. Failure to obtain prior authorization when required may result in reduced benefits or benefits may be denied. Complete details are found in the PHP Select PLUS 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.

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

Member materials, including the PHP Select PLUS Certificate of Coverage, can be found online at our Member Packet Portal. Use your member ID to access materials 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
- Experimental procedures
- Hearing aids
- Vision services
- Prescription drugs
- Custodial care, bed care, convenience care, day care, domiciliary care
- Non-network charges in excess of the Eligible Expenses as determined in accordance with our reimbursement policy guidelines

For additional information about exclusions and limitations, visit our web site, or contact the PHPMM Customer Service Department.

This Summary of Benefits is intended only to highlight the benefits provided under PHP Select 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 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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