

# PPO HDHP Benefit Summary MWH01200



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> (includes annual deductible)	\$2500 Single \$5000 Family	\$5000 Single \$10000 Family
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	
<b>POLICY YEAR</b>	October 1 through September 30	

TYPE OF BENEFITS	NETWORK BENEFITS AMOUNT COVERED	NON-NETWORK BENEFITS AMOUNT COVERED
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**PREVENTIVE HEALTH SERVICES \*See Preventive Services Card\*\*\***

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 care</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
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**PHYSICIAN OFFICE VISITS**

Office visits for illness or injury	100% after deductible	70% of Eligible Expenses (EE) after deductible
Maternity care – postpartum services	100% after deductible	70% of EE after deductible
Injections/infusions	100% after deductible	70% of EE after deductible

**INPATIENT HOSPITAL**

Inpatient hospital services	100% after deductible	70% of EE after deductible
Transplant services (at designated facilities)	100% after deductible	Not covered

**OUTPATIENT HOSPITAL**

Surgery and related services	100% after deductible	70% of EE after deductible
Diagnostic X-ray and laboratory, CT scans, PET scans, MRA, MRI & nuclear medicine	100% after deductible	70% of EE after deductible

**EMERGENCY/URGENT CARE**

At hospital emergency department	100% after deductible	Same as network benefit
At urgent care facility	100% after deductible	Same as network benefit
At non-network physician's office	100% after deductible	Same as network benefit

**BEHAVIORAL HEALTH SERVICES**

Inpatient mental health treatment	100% after deductible	70% of EE after deductible
Outpatient and intermediate mental health treatment	100% after deductible	70% of EE after deductible
Inpatient substance use disorders treatment (detoxification)	100% after deductible	70% of EE after deductible
Residential treatment program for substance use disorders	100% after deductible	70% of EE after deductible
Outpatient and intermediate substance use disorders treatment	100% after deductible	70% of EE after deductible

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<b>OTHER SERVICES</b>		
Home health agency services	100% after deductible <i>Combined network and non-network limit of 60 visits per policy year</i>	70% of EE after deductible
Skilled nursing facility services	100% after deductible <i>Combined network and non-network limit of 100 days per policy year</i>	70% of EE after deductible
Hospice care	100% after deductible	70% of EE after deductible
Ambulance services	100% after deductible	Same as Network benefit
Prosthetics	100% after deductible	70% of EE after deductible
Durable medical equipment	100% after deductible	70% of EE after deductible
Outpatient rehabilitation services	100% after deductible <i>Combined network and non-network limit of 60 visits per policy year for physical, speech, occupational and pulmonary; combined network and non-network limit of 36 visits per policy year for Phase I and II cardiac rehabilitation</i>	70% of EE after deductible
Spinal treatment	100% after deductible <i>Limited to 36 visits per policy year</i>	Not covered

**NOTE:** 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.

Certain covered health services must be authorized in advance by PHPMM-IC. The phone number to call to request authorization is on the member ID card. Covered health services must be Medically Necessary as determined by PHPMM-IC medical policy and nationally recognized guidelines.

Member materials, including the PPO HDHP Certificate of Coverage, can be found online at our Member Packet Portal. Members may 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).

Except as may be specifically provided through a Rider to the policy, exclusions include:

- Mental health services
- Spinal treatment
- Vision care
- Hearing aids
- Custodial care, bed care, convenience care, day care, domiciliary care
- Routine dental care
- Cosmetic surgery
- Experimental procedures
- Prescription drugs

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

This Summary of Benefits is intended only to highlight the Benefits provided under PHPMM-IC 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 Insurance Company 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) 364-8456 or (800) 203-9519.

### Important Notice on The Patient Protection and Affordable Care Act

PHPMM believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was all ready in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the your employer.

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**High Deductible Health Plan Prescription Drug Program**

Benefits are available for Outpatient Prescription Drug Products on our Prescription Drug List at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please access [www.medco.com](http://www.medco.com) through the Internet, or call the Customer Service number on your ID card to determine tier status.

**Deductible and Out-of-Pocket Maximums**

Before Benefits are available for outpatient Prescription Drug Products, you must meet the combined medical/prescription drug Network Annual Deductible stated in the PHPMM-IC HDHP PPO Certificate of Coverage.

For single coverage, the Annual Deductible is \$1250 per policy year. 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, the family Annual Deductible is \$2500 per Policy Year. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.

<b><u>Retail Copay</u></b>		<b><u>Mail Service Copay (up to a 90 day supply)</u></b>	
• Tier-1 Prescription Drug Product	\$10 after deductible	• Tier-1 Prescription Drug Product	\$20 after deductible
• Tier-2 Prescription Drug Product	\$25 after deductible	• Tier-2 Prescription Drug Product	\$50 after deductible
• Tier-3 Prescription Drug Product	\$50 after deductible	• Tier-3 Prescription Drug Product	\$100 after deductible

- 40% copay for growth hormone therapy – Retail or Mail Service

**Supply Limits**

- Retail: Up to 31 consecutive day supply
  - Mail: Up to 90 consecutive day supply
  - Some products may have additional quantity limits.
- Please consult with your physician. These specific quantity limits may be exceeded in certain situations at the request of your physician.

**Mail Service Convenience**

Mail Service Pharmacy allows you to have your prescriptions filled and delivered directly to your doorstep. You save on copays too. Call our Customer Service Department for more information. Our phone number is listed on the back of your ID card.

**Exclusions**

Some of the exclusions that apply to your benefit are listed below. Please look at your pharmacy rider in the PHPMM-IC HDHP PPO Certificate of Coverage for a complete listing.

- Experimental products
- Appetite suppressants and other weight loss products
- Over the counter drugs
- Replacement prescriptions
- Medications for cosmetic purposes only
- Prescription Drug Products to treat infertility

Please contact the plan Customer Service Department at the number listed on the back of your ID card if you have questions.