

PLAN DPW03700

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE	\$1000 per individual/\$2000 per family	\$2000 per individual/\$4000 per family
OUT-OF-POCKET MAXIMUM	\$2000 per individual/\$4000 per family	\$4000 per individual/\$8000 per family
LIFETIME MAXIMUM BENEFIT	Unlimited	
	AMOUNT COVERED	AMOUNT COVERED

PREVENTIVE HEALTH SERVICES *See Preventive Services Card*****

Routine physical exam	100%, deductible waived	Not covered
Well baby care	100%, deductible waived	Not covered
Immunizations	100%, deductible waived	Not covered
Routine eye exam	100%, deductible waived	Not covered
Preventive care outside physician's office	100%, deductible waived	Not covered

PHYSICIAN OFFICE VISITS

Office visits for illness or injury	100% after \$20/visit, deductible waived	60% of Eligible Expenses (EE) after deductible
Maternity care (pre and postnatal services)	100% after \$20/visit, deductible waived	60% of EE after deductible
Injections/infusions	100%, deductible waived	60% of EE after deductible

INPATIENT HOSPITAL

Unlimited days in a semi-private room	80% after deductible	60% of EE after deductible
Special care units	80% after deductible	60% of EE after deductible
Necessary ancillary hospital services	80% after deductible	60% of EE after deductible
Surgery and related services	80% after deductible	60% of EE after deductible
Anesthesia and its administration	80% after deductible	60% of EE after deductible
Transplant services (at designated facilities)	80% after deductible	Not covered
Maternity care (hospital services)	80% after deductible	60% of EE after deductible
Physician services including consultation	80% after deductible	60% of EE after deductible
Physician obstetrical services	80% after deductible	60% of EE after deductible

OUTPATIENT HOSPITAL

Surgery and related services	80% after deductible	60% of EE after deductible
Diagnostic X-ray and laboratory	80% after deductible	60% of EE after deductible
CT scans, PET scans, MRA, MRI and nuclear medicine	80% after deductible	60% of EE after deductible
Voluntary sterilization	80% after deductible	60% of EE after deductible

EMERGENCY/URGENT CARE

At hospital emergency department	100% after \$80/visit, deductible waived <i>Copayment waived if admitted for an inpatient stay</i>	Same as Network benefit
At urgent care facility (after-hour services)	100% after \$40/visit, deductible waived	Same as Network benefit
At non-network physician's office	100% after \$20/visit, deductible waived	Same as Network benefit

BEHAVIORAL HEALTH SERVICES

Inpatient treatment (including detoxification)	80% after deductible	60% of EE after deductible
Residential treatment for substance use disorders	80% after deductible	60% of EE after deductible
Intermediate treatment	80% after deductible	60% of EE after deductible
Outpatient office visits	100% after \$20/visit, deductible waived	60% of EE after deductible
All other outpatient items and services	100%, deductible waived	60% of EE after deductible

PPO Benefit Summary



PLAN DPW03700

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
	AMOUNT COVERED	AMOUNT COVERED
OTHER COVERED HEALTH SERVICES		
Home health care services	80% after deductible <i>Combined network and non-network limit of 60 visits per calendar year</i>	60% of EE after deductible
Skilled nursing facility services	80% after deductible <i>Combined network and non-network limit of 100 days per calendar year</i>	60% of EE after deductible
Hospice care	80% after deductible	60% of EE after deductible
Ambulance services	80% after deductible	Same as Network benefit
Prosthetics	80% after deductible	60% of EE after deductible
Durable medical equipment	80% after deductible	60% of EE after deductible
Outpatient rehabilitation services	100% after \$20/visit, deductible waived <i>Combined network and non-network limit of 60 visits per cy for physical, speech, occupational and pulmonary; combined network and non-network limit of 36 visits per CY for Phase I and II cardiac rehabilitation)</i>	60% of EE after deductible
Spinal treatment	100% after \$20/visit, deductible waived <i>Limited to 12 visits per calendar year</i>	Not covered

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 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.

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

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

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

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-IC 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.