IN NETWORK	**IN NETWORK**	**IN NETWORK**	**IN NETWORK**
	Physicians Health Plan PPO Plan DPW07500	**Dansville Schools Employee Benefit Plan**	**Employer Subsidized Amounts**

TYPE OF BENEFITS	NETWORK BENEFITS	EMPLOYEE BENEFITS	EMPLOYER FUNDED BENEFITS
ANNUAL DEDUCTIBLE	$4,000 per individual/$8,000 per family	None	$4,000 per individual/$8,000 per family
OUT-OF-POCKET MAXIMUM	None	None	None
LIFETIME MAXIMUM BENEFIT	Unlimited		
TYPE OF BENEFITS	**AMOUNT COVERED**	**AMOUNT COVERED**	**AMOUNT COVERED**
PREVENTIVE HEALTH SERVICES ***See Preventive Services Card***			
Routine physical exam	100%, deductible waived	100%, deductible waived	None
Well baby and well child care	100%, deductible waived	100%, deductible waived	None
Immunizations	100%, deductible waived	100%, deductible waived	None
Routine eye exam-*limit of 1 per CY*	100%, deductible waived	100%, deductible waived	None
Preventive care outside physician's office	100%, deductible waived	100%, deductible waived	None
PHYSICIAN'S OFFICE VISITS			
Office visit for illness or injury	100% after $30/visit, deductible waived	100% after $20/visit, deductible waived	$10 Office Visit Copay
Injections/infusions	100%, deductible waived	100%, deductible waived	None
INPATIENT HOSPITAL			
Unlimited days in semi-private room	100%, after deductible	100%, after deductible	Reference deductible
Special care units	100%, after deductible	100%, after deductible	Reference deductible
Necessary ancillary hospital services	100%, after deductible	100%, after deductible	Reference deductible
Surgery and related services	100%, after deductible	100%, after deductible	Reference deductible
Anesthesia and its administration	100%, after deductible	100%, after deductible	Reference deductible
Transplant services (at designated facilities)	100%, after deductible	100%, after deductible	Reference deductible
Maternity Care (hospital services)	100%, after deductible	100%, after deductible	Reference deductible
Physician services including consultation	100%, after deductible	100%, after deductible	Reference deductible
OUTPATIENT HOSPITAL			
Surgery and related services	100%, after deductible	100%, after deductible	Reference deductible
Diagnostic X-ray and laboratory	100%, after deductible	100%, after deductible	Reference deductible
CT scans, PET scans, MRA, MRI and nuclear medicine	100%, after deductible	100%, after deductible	Reference deductible
Voluntary sterilization	100%, after deductible	100%, after deductible	Reference deductible

IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK
	Physicians Health Plan PPO Plan DPW07500	**Dansville Schools Employee Benefit Plan**	**Employer Subsidized Amounts**
EMERGENCY/URGENT CARE			
At hospital emergency department	100% after $150/visit, deductible waived	100% after $75/visit, deductible waived	$75 Emergency Room Copay
	Copayment waived if admitted for an inpatient stay		
At urgent care facility (after-hour services)	100% after $30/visit, deductible waived	100% after $30/visit, deductible waived	None
At non-network physician's office	100% after $30/visit, deductible waived	100% after $30/visit, deductible waived	None
BEHAVIORAL HEALTH SERVICES			
Inpatient treatment (including detoxification)	100%, after deductible	100%, after deductible	Reference deductible
Residential treatment for substance use disorders	100%, after deductible	100%, after deductible	Reference deductible
Intermediate treatment	100%, after deductible	100%, after deductible	Reference deductible
Outpatient therapy visits and testing	100% after $30/visit, deductible waived	100% after $15/visit, deductible waived	$15 Outpatient Therapy Copay
All other outpatient items and services	100%, deductible waived	100%, deductible waived	None
OTHER COVERED HEALTH SERVICES			
Home health care services	100%, after deductible	100%, after deductible	Reference deductible
	Combined network and non-network limit of 60 visits per calendar year		
Skilled nursing facility services	100%, after deductible	100%, after deductible	Reference deductible
	Combined network and non-network limit of 100 days per calendar year		
Hospice care	100%, after deductible	100%, after deductible	Reference deductible
Physician obstetrical services (prenatal, delivery and postnatal)	100%, after deductible	100%, after deductible	Reference deductible
Ambulance	100%, after deductible	100%, after deductible	Reference deductible
Prosthetics	100%, after deductible	100%, after deductible	Reference deductible
Durable medical equipment	100%, after deductible	100%, after deductible	Reference deductible
Outpatient rehabilitation services	100% after $30/visit, deductible waived	100% after $15/visit, deductible waived	$15 Outpatient Rehab Copay
	Combined network and non-network limit of 60 visits per calendar year for physical, speech, occupational and pulmonary; combined network and non-network limit of 36 visits per calendar year for Phase I and II cardiac rehabilitation		
Spinal Treatment	100% after $20/visit, deductible waived	100% after $20/visit, deductible waived	None
	Limited to 36 visits per calendar year		

NON-NETWORK	NON-NETWORK	NON-NETWORK	NON-NETWORK
	Physicians Health Plan PPO Plan DPW07500	**Dansville Schools Employee Benefit Plan**	**Employer Subsidized Amounts**

TYPE OF BENEFITS	NETWORK BENEFITS	EMPLOYEE BENEFITS	EMPLOYER FUNDED BENEFITS
ANNUAL DEDUCTIBLE	$8,000 per individual/$16,000 per family	$8,000 per individual/$16,000 per family	None
OUT-OF-POCKET MAXIMUM	$16,000 per individual/$32,000 per family	$16,000 per individual/$32,000 per family	None
LIFETIME MAXIMUM BENEFIT	Unlimited		
TYPE OF BENEFITS	**AMOUNT COVERED**	**AMOUNT COVERED**	**AMOUNT COVERED**
PREVENTIVE HEALTH SERVICES ***See Preventive Services Card***			
Routine physical exam	Not covered	Not covered	None
Well baby and well child care	Not covered	Not covered	None
Immunizations	Not covered	Not covered	None
Routine eye exam-limit of 1 per CY	Not covered	Not covered	None
Preventive care outside physician's office	Not covered	Not covered	None
PHYSICIAN'S OFFICE VISITS			
Office visit for illness or injury	80% of Eligible Expenses (EE) after deductible	80% of Eligible Expenses (EE) after deductible	None
Injections/infusions	80% of (EE) after deductible	80% of (EE) after deductible	None
INPATIENT HOSPITAL			
Unlimited days in semi-private room	80% of (EE) after deductible	80% of (EE) after deductible	None
Special care units	80% of (EE) after deductible	80% of (EE) after deductible	None
Necessary ancillary hospital services	80% of (EE) after deductible	80% of (EE) after deductible	None
Surgery and related services	80% of (EE) after deductible	80% of (EE) after deductible	None
Anesthesia and its administration	80% of (EE) after deductible	80% of (EE) after deductible	None
Transplant services (at designated facilities)	Not covered	Not covered	None
Maternity Care (hospital services)	80% of (EE) after deductible	80% of (EE) after deductible	None
Physician services including consultation	80% of (EE) after deductible	80% of (EE) after deductible	None
OUTPATIENT HOSPITAL			
Surgery and related services	80% of (EE) after deductible	80% of (EE) after deductible	None
Diagnostic X-ray and laboratory	80% of (EE) after deductible	80% of (EE) after deductible	None
CT scans, PET scans, MRA, MRI and nuclear medicine	80% of (EE) after deductible	80% of (EE) after deductible	None
Voluntary sterilization	80% of (EE) after deductible	80% of (EE) after deductible	None

NON-NETWORK	NON-NETWORK	NON-NETWORK	NON-NETWORK
	Physicians Health Plan PPO Plan DPW07500	**Dansville Schools Employee Benefit Plan**	**Employer Subsidized Amounts**
EMERGENCY/URGENT CARE			
At hospital emergency department	Same as Network benefit	Same as Network benefit	See In-Network Benefits
	Copayment waived if admitted for an inpatient stay		
At urgent care facility (after-hour services)	Same as Network benefit	Same as Network benefit	None
At non-network physician's office	Same as Network benefit	Same as Network benefit	None
BEHAVIORAL HEALTH SERVICES			
Inpatient treatment (including detoxification)	80% of (EE) after deductible	80% of (EE) after deductible	None
Residential treatment for substance use disorders	80% of (EE) after deductible	80% of (EE) after deductible	None
Intermediate treatment	80% of (EE) after deductible	80% of (EE) after deductible	None
Outpatient therapy visits and testing	80% of (EE) after deductible	80% of (EE) after deductible	None
All other outpatient items and services	80% of (EE) after deductible	80% of (EE) after deductible	None
OTHER COVERED HEALTH SERVICES			
Home health care services	80% of (EE) after deductible	80% of (EE) after deductible	None
	Combined network and non-network limit of 60 visits per calendar year		
Skilled nursing facility services	80% of (EE) after deductible	80% of (EE) after deductible	None
	Combined network and non-network limit of 100 days per calendar year		
Hospice care	80% of (EE) after deductible	80% of (EE) after deductible	None
Physician obstetrical services (prenatal, delivery and postnatal)	80% of (EE) after deductible	80% of (EE) after deductible	None
Ambulance	80% of (EE) after deductible	80% of (EE) after deductible	None
Prosthetics	80% of (EE) after deductible	80% of (EE) after deductible	None
Durable medical equipment	80% of (EE) after deductible	80% of (EE) after deductible	None
Outpatient rehabilitation services	80% of (EE) after deductible	80% of (EE) after deductible	None
	Combined network and non-network limit of 60 visits per calendar year for physical, speech, occupational and pulmonary; combined network and non-network limit of 36 visits per calendar year for Phase I and II cardiac rehabilitation		
Spinal Treatment	Not covered	Not covered	None

AMERA | PLAN
Group Benefits | Administration

Self-Funded Hearing Rider
Dansville Schools

HEARING CARE BENEFIT - Plan pays up to $2,000 for all covered services per covered individual	Hearing Care Benefits are payable once every thirty-six (36) months.
	Hearing Care Benefits are paid at 100% of the approved amount only when services are received in the following order:
	First, you must have a medical examination of the ear perfomed by a participating board-certified or board-eligible otologist, otolaryngologist or otorhinolaryngologist. *This examination is NOT a Hearing Care Benefit.*
	Then, within six (6) months, you must receive the following services from a participating provider (see below for participating providers) in the order listed.
	1. **Audiometric Examination** - measures heaing ability, including tests for air and bone-conduction, speech reception and speech discrimination.
	2. **Hearing Aid Evaluation** - determines what type of hearing aid should be prescribed to compensate for loss of hearing.
	3. **Ordering and Fitting the Hearing Aid** - includes in-the-ear, behind-the-ear, and basic hearing aids worn on the body, with ear molds, if necessary
	4. **Conformity Test** - evaluates the performance of a hearing aid and its conformity to the original prescription after it has been fitted.
	Your Hearing Care coverage DOES NOT cover:
	1. Your medical examination to determine possible loss of hearing
	2. An examination by an audiologist that has not been ordered by a physician specialist
	3. A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
	4. Replacement of hearing aids that are lost or broken, unless this occurs after 36 months when the benefits are renewed
	5. Repairs and replacement of parts
	6. The difference in cost between an eyeglass-type hearing aid and a behind-the-ear hearing aid
	7. All hearing care services and supplies provided by a non-participating provider
	8. Charges for digital-controlled programmable hearing devices beyond the amount the Plan pays for a basic hearing aid
	9. Hearing aids that do not meet Food and Drug Administration (FDA) and Federal Trade Commission (FTC) requirements
	Limitations:
	$1750 Max for Hearing Aid alone
	$250 for all other benefits combined

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 PHPMM-IC Certificate of Coverage, can be found online at our Member Packet Portal. Use the Product ID code at the bottom right to access your benefits on the Member Packet Portal through our website 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
- 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.

Important Notice on Patient Protection Provisions Included in Your Plan as Part of the Patient Protection and Affordable Care Act

You do not need authorization from us or from any other person in order to obtain access to obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology. However, the Network provider may be required to obtain authorization prior to certain services, which are listed in your Certificate of Coverage.

Your Plan covers Emergency Health Services in any hospital emergency department. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Health Services at a Non-Network facility. However, a Non-Network provider may send you a bill for any charges remaining after your plan has paid.