Benefit Summary for Gold 1000 PPO Plan

PHP Insurance Company

Plan GFH00500-RX03F329

TYPE OF BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE:	$1,000 per individual/$2,000 per family	$3,500 per individual/$7,000 per family
ANNUAL MAXIMUM OUT-OF-POCKET: (includes deductible, coinsurance, copays)	$5,000 per individual/$10,000 per family	$7,000 per individual/$14,000 per family
This plan does not contain an annual or lifetime limit on the dollar amount of Essential Health Benefits.		

	AMOUNT COVERED	AMOUNT COVERED
PREVENTIVE HEALTH SERVICES including but not limited to:		
• Routine physical exams • Related pathology and radiology services • Well baby and well child care • Immunizations • Routine screening mammography	100%, deductible waived	Not covered
Tobacco cessation program	100%, deductible waived	Not covered
PHYSICIAN OFFICE VISITS		
Physician professional fee (non-preventive) • PCP • Specialist	 100% after $25/visit, deductible waived 100% after $50/visit, deductible waived	 70% of Eligible Expenses (EE) after deductible
Maternity care (prenatal, delivery & postnatal)	80% after deductible	70% of EE after deductible
Injections/infusions	80% after deductible	70% of EE after deductible
Allergy testing and therapy	50% after deductible	Not covered
Other associated services	80% after deductible	70% of EE after deductible
INPATIENT HOSPITAL SERVICES		
Unlimited days in a semi-private room; special care units; necessary ancillary hospital services; surgery; anesthesia and its administration; maternity care (hospital services); physician services, including consultation	80% after deductible	70% of EE after deductible
OUTPATIENT SERVICES		
Surgical sterilization-female and related services	100%, deductible waived	70% of EE after deductible
All other surgery (except as noted)	80% after deductible	70% of EE after deductible
Diagnostic X-ray and laboratory	80% after deductible	70% of EE after deductible
Diagnostic high tech radiology and nuclear medicine	100% after $150/procedure after deductible	70% of EE after deductible
Diagnostic services (such as certain endoscopic and cardiac procedures)	80% after deductible	70% of EE after deductible
EMERGENCY/URGENT CARE		
At hospital emergency department	100% after $300/visit after deductible	Same as Network benefit
At urgent care facility	100% after $60/visit, deductible waived	Same as Network benefit
At non-network physician's office outside the service area	100% after $25/visit, deductible waived	Same as Network benefit

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BEHAVIORAL HEALTH SERVICES		
Inpatient treatment (including detoxification)	80% after deductible	70% of EE after deductible
Residential treatment program	80% after deductible	70% of EE after deductible
Intermediate treatment	80% after deductible	70% of EE after deductible
Outpatient therapy visits and testing	100% after $25/visit, deductible waived	70% of EE after deductible
All other outpatient services	80% after deductible	70% of EE after deductible
OTHER SERVICES		
Ambulance services	80% after deductible	Same as network benefit
Autism Spectrum Disorders treatment (for children from birth through age 18)	OP habilitative therapy: 100% after $50/visit after deductible; ABA: 80% after deductible	Not covered
Bariatric, orthognathic, reduction mammoplasty & TMJ surgery	50% after deductible	Not covered
Durable medical equipment/orthotics	50%, deductible waived	Not covered
Home health care	80% after deductible	70% of EE after deductible
Home infusion therapy	80% after deductible	70% of EE after deductible
Non-hospital facility (hospice facility, skilled nursing facility, inpatient rehabilitation facility)	80% after deductible	70% of EE after deductible *Combined network and non-network limit of 45 days per CY*
Hospice care in the home	80% after deductible	70% of EE after deductible
Nutritional counseling (non-preventive)	80% after deductible	Not covered
Outpatient rehabilitation therapy	100% after $50/visit after deductible	70% of EE after deductible *Combined network and non-network limits per CY: PT/OT= 30 visits; ST = 30 visits; cardiac/pulmonary = 30 visits*
Pediatric vision services (limitations apply) • Routine vision exam • Eyewear, contacts, other services	 100%, deductible waived 80% after deductible	 Not covered Not covered
Prescription drugs (outpatient) * • Tier 1 at retail pharmacy • Tier 2 at retail pharmacy • Tier 3 at retail pharmacy • Tier 4 at retail pharmacy • Mail-order service (up to 90-day supply)	Deductible waived: 100% after $20/order or refill 100% after $50/order or refill 100% after $80/order or refill 100% after $150/order or refill 100% after 2 copays	Not covered
Prosthetic devices	50%, deductible waived	Not covered
Spinal treatment by chiropractor or D.O.	100% after $30/visit after deductible	70% of EE after deductible *Combined network and non-network limit of 30 visits per CY*
TMJ treatment	50% after deductible	Not covered
Transplant services (at designated facilities)	80% after deductible	Not covered
Weight management services	50% after deductible	Not covered

* If you want or your physician wants you to have a brand-name drug that has a generic drug that is chemically the same, you pay your applicable copay plus an Ancillary Charge, which is the difference between the cost of the brand-name drug and the generic drug. Exclusions include but are not limited to:

- Routine dental care
- Cosmetic surgery
- Hearing aids and services
- Elective abortion
- Experimental or investigational procedures and services
- Custodial care, bed care, convenience care, day care, domiciliary care
- Adult vision services

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