Benefit Summary
PHP PPO Gold 3000 H.S.A.

Medical: GFW00323 **RX: RX07F521**

Your employer's H.S.A. covers up to $200 per individual or $400 per family of your annual health care cost share

TYPE OF BENEFITS	NETWORK		NON-NETWORK	
ANNUAL DEDUCTIBLE (Embedded)	$3,000	Individual	$6,000	Individual
	$6,000	Family	$12,000	Family
COINSURANCE (member responsibility after deductible, unless stated otherwise below)	0%		40%	
ANNUAL OUT-OF-POCKET MAXIMUM (Embedded) (includes deductible, coinsurance, copays)	$6,750	Individual	$12,000	Individual
	$13,500	Family	$24,000	Family
This Benefit plan does not contain an annual or lifetime limit on the dollar amount of Essential Health Benefits.				

BENEFIT		MEMBER COST SHARE	
PHYSICIAN OFFICE VISITS		**NETWORK**	**NON-NETWORK**
Physician (includes PCP, OB/GYN and behavioral health)		0% after deductible	40% after deductible
Specialist (includes dentist or oral surgeon)		0% after deductible	40% after deductible
• Injections and infusions		0% after deductible	40% after deductible
• Allergy testing and therapy		0% after deductible	Not covered
• Allergy injections		0% after deductible	40% after deductible
• Associated services		0% after deductible	40% after deductible
PREVENTIVE HEALTH SERVICES - ***Including but not limited to:***		**NETWORK**	**NON-NETWORK**
• Physical exam - annual routine	• Tobacco cessation program	No charge	Not covered
• Well baby and well child care	• Immunizations		
• Laboratory services - routine	• Pap smears		
• Nutritional counseling	• Mammography - screening		
INPATIENT HOSPITAL		**NETWORK**	**NON-NETWORK**
• Surgery		0% after deductible	40% after deductible
• Semi-private room or special care unit (unlimited days)			
• Anesthesia - including administration			
• Physician services - including consultation			
• Necessary ancillary hospital services			
SPECIAL SURGERIES AND SERVICES		**NETWORK**	**NON-NETWORK**
• Breast reduction, orthognathic, TMJ, male mastectomy		0% after deductible	Not covered
• Bariatric surgery and qualified weight management programs		0% after deductible	Not covered
OUTPATIENT SERVICES		**NETWORK**	**NON-NETWORK**
• X-ray, tests and procedures - diagnostic		0% after deductible	40% after deductible
• Laboratory and pathology - diagnostic		0% after deductible	40% after deductible
• Surgery (all other)		0% after deductible	40% after deductible
• High tech radiology and nuclear medicine		0% after deductible	40% after deductible
• Chiropractic services	Limit - 30 visits per calendar year	0% after deductible	40% after deductible
Outpatient Rehabilitation/Habilitation Therapy:			
• Physical	Combined limit - 30 visits per calendar year each for rehabilitation and habilitation	0% after deductible	40% after deductible
• Occupational		0% after deductible	40% after deductible
• Speech	Limit - 30 visits per calendar year each for rehabilitation and habilitation	0% after deductible	40% after deductible
• Pulmonary	Combined limit - 30 visits per calendar year each for rehabilitation and habilitation	0% after deductible	40% after deductible
• Cardiac		0% after deductible	40% after deductible
EMERGENCY AND URGENT HEALTH SERVICES		**NETWORK**	**NON-NETWORK**
Emergency Health Services:			
• Emergency Department visit (copay waived if admitted inpatient)		0% after deductible	Same as network benefit
• Associated services		0% after deductible	
• Ambulance services		0% after deductible	
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• Urgent care center visit		0% after deductible	Same as network benefit
• Associated services		0% after deductible	
• Convenience care facility visit (ex., Sparrow FastCare)		0% after deductible	40% after deductible
• Associated services		0% after deductible	40% after deductible
• Telehealth visit - Amwell Acute Care		0% after deductible	N/A

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BEHAVIORAL HEALTH SERVICES		NETWORK	NON-NETWORK
● Therapy visits and testing - outpatient		0% after deductible	40% after deductible
● Inpatient treatment - including detoxification		0% after deductible	40% after deductible
● Residential treatment program and intermediate treatment		0% after deductible	40% after deductible
● All other outpatient services		0% after deductible	40% after deductible
● Telehealth visit - Amwell Behavioral Health		0% after deductible	N/A
OTHER SERVICES		**NETWORK**	**NON-NETWORK**
● Durable medical equipment (DME) and prosthetic devices		0% after deductible	Not covered
● Home health care		0% after deductible	40% after deductible
● Hospice - facility	Limit - 45 days per calendar year	0% after deductible	40% after deductible
● Hospice - home		0% after deductible	40% after deductible
● Skilled nursing facility (SNF)	Limit - 45 days per calendar year	0% after deductible	40% after deductible
● IP rehabilitation facility	Limit - 45 days per calendar year	0% after deductible	40% after deductible
● Surgical sterilization - female		No charge	40% after deductible
● Surgical sterilization - male		0% after deductible	40% after deductible
● Infertility treatment (to treat the underlying conditions that result in infertility)		Covered as any other medical condition	40% after deductible
● ABA services for treatment of Autism Spectrum Disorders		0% after deductible	Not covered
Pediatric Vision Services:			
● Pediatric routine eye exam	Limit - 1 exam per calendar year	No charge	Not covered
● Pediatric glasses	Limit - 1 pair per calendar year	0% after deductible	Not covered
● Pediatric contacts	Limit - 1 year's supply in lieu of glasses	0% after deductible	Not covered
PHARMACY BENEFITS		**NETWORK**	**NON-NETWORK**
***Outpatient Prescription Drugs:**		**All are after deductible:**	
● Tier 1A - (up to 31-day supply)		$5 per order or refill	Not covered
● Tier 1B - (up to 31-day supply)		$20 per order or refill	
● Tier 2 - (up to 31-day supply)		$60 per order or refill	
● Tier 3 - (up to 31-day supply)		$80 per order or refill	
● Tier 4 - (up to 31-day supply)		20% to maximum of $200 per order or refill	
● Tier 5 - (up to 31-day supply)		20% to maximum of $300 per order or refill	
● 90-day supply		2 copays	
● Specialty medications (up to 31-day supply)		CVS mail-order only	
● Select prescription drugs for ACA preventive coverage		No charge	
● Tier 1A drugs are available in up to a 90-day supply from retail network pharmacies		2 copays	

*Ancillary charge (RX): If you 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 or coinsurance amount plus an ancillary charge (the difference between the cost of the brand-name drug and the generic drug).

Associated services: charges for diagnostic or supportive services (ex,. lab/path, radiology, professional fees, medical supplies)

Certain covered health services must be approved in advance by PHP. The phone number to call to request approval is on the member ID card. Covered Health Services must be medically necessary as determined by PHP medical policy and nationally recognized guidelines. Member materials, including the Certificate of Coverage, can be found online at our Member Reference Desk. Members may access benefit information on the Member Reference Desk through our website at www.phpmichigan.com. Exclusions include:

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

For additional information about Exclusions, contact our Customer Service Department or review the Certificate of Coverage for this Policy. This Summary of Benefits is intended only to highlight the Benefits provided under PHP [Insurance Company] and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. 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 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. *1/22*