# Benefit Summary
# Physicians Health Plan HMO Exclusive Gold Core HRA

**Medical: GFC08924** **RX: RX0HF023**

Your employer's HRA covers up to $250 per individual or $500 per family of your annual health care cost share

| TYPE OF BENEFITS | NETWORK | | NON-NETWORK | |
|---|---|---|---|---|
| **ANNUAL DEDUCTIBLE** (Embedded) | $5,000 | Individual | N/A | Individual |
| | $10,000 | Family | N/A | Family |
| **COINSURANCE** (member responsibility after deductible, unless stated otherwise below) | 20% | | N/A | |
| **ANNUAL OUT-OF-POCKET MAXIMUM** (Embedded) (includes deductible, coinsurance, copays) | $7,000 | Individual | N/A | Individual |
| | $14,000 | Family | N/A | 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) | | $40 per visit, deductible waived | Not covered |
| Specialist (includes dentist or oral surgeon) | | $40 per visit, deductible waived | Not covered |
| • Injections and infusions | | 20% after deductible | Not covered |
| • Allergy testing and therapy | | 50% after deductible | Not covered |
| • Allergy injections | | 20% after deductible | Not covered |
| • Associated services | | 20% after deductible | Not covered |
| **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 | | 20% after deductible | Not covered |
| • 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 | | 50% after deductible | Not covered |
| • Bariatric surgery and qualified weight management programs | | 50% after deductible | Not covered |
| **OUTPATIENT SERVICES** | | **NETWORK** | **NON-NETWORK** |
| • X-ray, tests and procedures - diagnostic | | 20% after deductible | Not covered |
| • Laboratory and pathology - diagnostic | | 20% after deductible | Not covered |
| • Surgery (all other) | | 20% after deductible | Not covered |
| • High tech radiology and nuclear medicine | | 20% after deductible | Not covered |
| • Chiropractic services | Limit - 30 visits per calendar year | $30 per visit after deductible | Not covered |
| **Outpatient Rehabilitation/Habilitation Therapy:** | | | |
| • Physical | Combined limit - 30 visits per calendar year each for rehabilitation and habilitation | 20% after deductible | Not covered |
| • Occupational | | 20% after deductible | Not covered |
| • Speech | Limit - 30 visits per calendar year each for rehabilitation and habilitation | 20% after deductible | Not covered |
| • Pulmonary | Combined limit - 30 visits per calendar year each for rehabilitation and habilitation | 20% after deductible | Not covered |
| • Cardiac | | 20% after deductible | Not covered |
| **EMERGENCY AND URGENT HEALTH SERVICES** | | **NETWORK** | **NON-NETWORK** |
| **Emergency Health Services:** | | | |
| • Emergency Department visit (copay waived if admitted inpatient) | | $250 per visit, deductible waived | Same as network benefit |
| • Associated services | | 20% after deductible | |
| • Ambulance services | | 20% after deductible | |
| \ | | | |
| • Urgent care center visit | | $60 per visit, deductible waived | Same as network benefit |
| • Associated services | | 20% after deductible | |
| • Convenience care facility visit (ex., Sparrow FastCare) | | $40 per visit, deductible waived | Not covered |
| • Associated services | | 20% after deductible | Not covered |
| • Telehealth visit - Amwell Acute Care | | $5 per visit, deductible waived | N/A |

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| BEHAVIORAL HEALTH SERVICES | | NETWORK | NON-NETWORK |
|---|---|---|---|
| ● Therapy visits and testing - outpatient | | $40 per visit, deductible waived | Not covered |
| ● Inpatient treatment - including detoxification | | 20% after deductible | Not covered |
| ● Residential treatment program and intermediate treatment | | 20% after deductible | Not covered |
| ● All other outpatient services | | 20% after deductible | Not covered |
| ● Telehealth visit - Amwell Behavioral Health | | $40 per visit, deductible waived | N/A |
| **OTHER SERVICES** | | **NETWORK** | **NON-NETWORK** |
| ● Durable medical equipment (DME) and prosthetic devices | | 50%, deductible waived | Not covered |
| ● Home health care | | 20% after deductible | Not covered |
| ● Hospice - facility | Limit - 45 days per calendar year | 20% after deductible | Not covered |
| ● Hospice - home | | 20% after deductible | Not covered |
| ● Skilled nursing facility (SNF) | Limit - 45 days per calendar year | 20% after deductible | Not covered |
| ● IP rehabilitation facility | Limit - 45 days per calendar year | 20% after deductible | Not covered |
| ● Surgical sterilization - female | | No charge | Not covered |
| ● Surgical sterilization - male | | 20% after deductible | Not covered |
| ● Infertility treatment (to treat the underlying conditions that result in infertility) | | Covered as any other medical condition | Not covered |
| ● ABA services for treatment of Autism Spectrum Disorders | | 20% 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 | 20% after deductible | Not covered |
| ● Pediatric contacts | Limit - 1 year's supply in lieu of glasses | 20% after deductible | Not covered |
| **PHARMACY BENEFITS** | | **NETWORK** | **NON-NETWORK** |
| ***Outpatient Prescription Drugs:** | | | |
| ● Tier 1A - (up to 31-day supply) | | $15 per order or refill | Not covered |
| ● Tier 1B - (up to 31-day supply) | | $40 per order or refill | |
| ● Tier 2 - (up to 31-day supply) | | $80 per order or refill | |
| ● Tier 3 - (up to 31-day supply) | | $200 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 | |

*Brand Generic Difference (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 brand generic difference 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. *1/23*