Benefit Summary
Physicians Health Plan HMO Exclusive Platinum Elite Plus

Medical: PFC00724 **RX: RX0HF010**

TYPE OF BENEFITS	NETWORK		NON-NETWORK	
ANNUAL DEDUCTIBLE (Embedded)	$750	Individual	N/A	Individual
	$1,500	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)	$2,600	Individual	N/A	Individual
	$5,200	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)		$20 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		$150 per procedure 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	$40 per visit after deductible	Not covered
• Occupational		$40 per visit after deductible	Not covered
• Speech	Limit - 30 visits per calendar year each for rehabilitation and habilitation	$40 per visit after deductible	Not covered
• Pulmonary	Combined limit - 30 visits per calendar year each for rehabilitation and habilitation	$40 per visit after deductible	Not covered
• Cardiac		$40 per visit after deductible	Not covered
EMERGENCY AND URGENT HEALTH SERVICES		**NETWORK**	**NON-NETWORK**
Emergency Health Services:			
• Emergency Department visit (copay waived if admitted inpatient)		$150 per visit after deductible	Same as network benefit
• Associated services		20% after deductible	
• Ambulance services		20% after deductible	
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• Urgent care center visit		$50 per visit, deductible waived	Same as network benefit
• Associated services		20% after deductible	
• Convenience care facility visit (ex., Sparrow FastCare)		$20 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		$20 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		$20 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)		$5 per order or refill	Not covered
• Tier 1B - (up to 31-day supply)		$15 per order or refill	
• Tier 2 - (up to 31-day supply)		$40 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	

*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*