
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, you can access our [Member Reference Desk](#) or by calling 1.866.539.3342 or 517.364.8567 locally. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1.866.539.3342 or 517.364.8567 locally to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$5,000 individual / \$10,000 family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and services subject to copayments (unless stated otherwise) are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,350 individual / \$14,700 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.phpmichigan.com">www.phpmichigan.com</a> or call 1.800.832.9186 or 517.364.8500 locally for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$40 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply 30% <a href="#">coinsurance</a> for ancillary services	Not covered	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply 30% <a href="#">coinsurance</a> for ancillary services	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.caremark.com/wps/portal">https://www.caremark.com/wps/portal</a>	Tier 1 drugs (mostly Generic)	\$30 <a href="#">copay</a> /prescription (retail) \$60 <a href="#">copay</a> /prescription (mail order)	Only covered for emergent/urgent condition.	<a href="#">Deductible</a> does not apply to outpatient prescription drug <a href="#">copays</a> . Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription). ACA mandated preventive drugs such as select contraceptive and tobacco cessation medications are covered with no member cost share. Preferred Tobacco Cessation Products and all Specialty Drugs regardless of tier placement are not available from mail-order service. Some drugs require prior approval for coverage. Call PHP for more information.
	Tier 2 drugs (mostly Preferred brand-name)	\$65 <a href="#">copay</a> /prescription (retail) \$130 <a href="#">copay</a> /prescription (mail order)	Only covered for emergent/urgent condition.	
	Tier 3 drugs (mostly Non-Preferred brand-name)	\$150 <a href="#">copay</a> /prescription (retail) \$300 <a href="#">copay</a> /prescription (mail order)	Only covered for emergent/urgent condition.	
	Tier 4 Non-Preferred <a href="#">Specialty drugs</a>	\$200 <a href="#">copay</a> /prescription (retail) Not available (mail order)	Only covered for emergent/urgent condition.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not covered	Female sterilization is covered at no member cost share when using network providers. Prior approval required for coverage of reconstructive procedures.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	Female sterilization is covered at no member

\* For more information about limitations and exceptions, see the plan or policy document at [www.phpmichigan.com](http://www.phpmichigan.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				cost share when using network providers. Prior approval required for coverage of reconstructive procedures.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$425 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply 30% <a href="#">coinsurance</a> for ancillary services	Same as network benefit	Prior approval required and copay waived if admitted for an inpatient stay.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	Same as network benefit	Prior approval required for coverage prior to non-emergency transport.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply 30% <a href="#">coinsurance</a> for ancillary services	Same as network benefit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	Not covered	Prior approval required for coverage. Transplants must be at Designated Facilities.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply 30% <a href="#">coinsurance</a> for ABA services for autism treatment	Not covered	Prior approval required for coverage of non-routine services including ABA services.
	Inpatient services	30% <a href="#">coinsurance</a>	Not covered	Prior approval required for coverage.
If you are pregnant	Office visits	Included in professional services below	Not covered	Certain prenatal tests are covered with no member cost share when using network providers. Prior approval required for coverage if inpatient stay exceeds federally established minimum time frames. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound.).
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Not covered	Prior approval required for coverage.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	Calendar year maximums: outpatient speech therapy – 30 visits; outpatient physical therapy,

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>needs</b>				occupational therapy and spinal treatment – 30 visits; pulmonary and cardiac rehabilitation therapy – 30 visits. Prior approval required for coverage of all services except spinal treatment.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	Calendar year maximums: outpatient speech therapy – 30 visits; outpatient physical therapy, occupational therapy and spinal treatment – 30 visits. Covered services for treatment of autism are not included in above limits. Prior approval required for all services except spinal treatment. Prior approval required for coverage.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not covered	Combined limit for skilled nursing facility care and hospice facility care of 45 days per calendar year. Prior approval required for coverage.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not covered	Prior approval required for coverage of certain items of DME. Call PHP for current information.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Not covered	Combined limit for hospice facility care and skilled nursing facility care of 45 days per calendar year. Prior approval required for coverage.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	This is a preventive service. Limited to 1 routine exam per calendar year.
	Children's glasses	30% <a href="#">coinsurance</a>	Not covered	Limited to 1 pair of glasses per calendar year. Other limitations apply.
	Children's dental check-up	Not covered	Not covered	This plan has no coverage for this service.

\* For more information about limitations and exceptions, see the plan or policy document at [www.phpmichigan.com](http://www.phpmichigan.com).

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic Surgery</li><li>• Dental Care</li></ul> | <ul style="list-style-type: none"><li>• Elective abortion as defined by the State of Michigan</li><li>• Hearing aids and services</li><li>• Infertility treatment to conceive a pregnancy</li><li>• Long term care</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private duty nursing</li><li>• Routine eye care (adult)</li><li>• Routine foot care</li></ul> |
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Bariatric surgery if meet criteria-30% <a href="#">coinsurance</a>, network only, prior approval required for coverage</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care-30% <a href="#">coinsurance</a>, to overall limit of 30 visits per calendar year (limit combined with other outpatient rehabilitation therapies), network only</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment to treat the underlying conditions that result in infertility only-30% <a href="#">coinsurance</a>, network only</li><li>• Weight loss programs-30% <a href="#">coinsurance</a>, network only</li></ul> |
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact PHP at 1.800.832.9186 or 517.364.8500 locally.

#### **Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### **Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### **Language Access Services:**

If you, or someone you are helping, has questions about this Benefit plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call our Customer Service Department at 517.364.8500 or 800.832.9186.

**Spanish** Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de PHP, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 517.364.8500 - 800.832.9186.

#### **Arabic**

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص PHP، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 517.364.8500 - 800.832.9186.

**Chinese** 如果您，或是您正在協助的對象，有關於[插入項目的名稱 PHP]方面的問題，您

有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 517.364.8500 - 800.832.9186]。

**German** Falls Sie oder jemand, dem Sie helfen, Fragen zum PHP haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 517.364.8500 - 800.832.9186 an.

**Italian** Se tu o qualcuno che stai aiutando avete domande su PHP, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 517.364.8500 - 800.832.9186.

**Japanese** ご本人様、またはお客様の身の回りの方でも、PHP についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、517.364.8500 - 800.832.9186 までお電話ください。



About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) \$60
- Hospital (facility) 30%
- Other 30%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,630
Copayments	\$0
Coinsurance	\$3,720
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,410</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) \$60
- Hospital (facility) 30%
- Other 30%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$94
Copayments	\$3,635
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$49
<b>The total Joe would pay is</b>	<b>\$3,818</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) \$60
- Hospital (facility) 30%
- Other 30%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,142
Copayments	\$180
Coinsurance	\$490
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,812</b>