Sparrow PHP Platinum Practical Exclusive Plan

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Plan: PNA00400-RX08E361

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.phpmichigan.com** or by calling **1-800-832-9186 or 517-364-8500 locally**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** individual / **$1,500** family Does not apply to copays and preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,200** individual / **$2,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.phpmichigan.com or call 1-800-832-9186 or 517-364-8500 locally.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-832-9186 or 517-364-8500 locally or visit us at **www.phpmichigan.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-832-9186 or 517-364-8500 locally to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not covered	Ancillary services may be subject to deductible and coinsurance.
	Specialist visit	$50 copay/visit	Not covered	Ancillary services may be subject to deductible and coinsurance.
	Other practitioner office visit	20% coinsurance for spinal treatment services by chiropractor or D.O.	Not covered	Chiropractic services, spinal manipulation services by a D.O., and outpatient physical and occupational therapy are limited to a combined maximum of 30 visits per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is	Tier 1 drugs (mostly generic)	$20 copay/prescription (retail) $40 copay/prescription (mail order)	Only covered for emergent/urgent condition	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Select contraceptive and tobacco cessation medications covered with no member cost share. Tobacco cessation medications are not
	Tier 2 drugs (mostly Preferred brand name)	$40 copay/prescription (retail) $80 copay/prescription	Only covered for emergent/urgent	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
available at www.express-scripts.com.		(mail order)	condition.	available from mail-order service. Some drugs require authorization. Call PHP for more information.
	Tier 3 drugs (mostly non-Preferred brand name)	$80 copay/prescription (retail) $160 copay/prescription (mail order)	Only covered for emergent/urgent condition.	
	Specialty drugs (such as growth hormone therapy and infertility medications)	Tier level depends on the drug. Please see the drug formulary list available online or contact Customer Service.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Female sterilization is covered at no member cost share when using network providers. Authorization required for reconstructive procedures.
	Physician/surgeon fees	20% coinsurance	Not covered	Female sterilization is covered at no member cost share when using network providers. Authorization required for reconstructive procedures.
If you need immediate medical attention	Emergency room services	$200 copay/visit	Same as network benefit	Ancillary services may be subject to deductible and coinsurance. Authorization required and copay waived if admitted for an inpatient stay.
	Emergency medical transportation	20% coinsurance	Same as network benefit	Authorization required prior to non-emergency transport.
	Urgent care	$50 copay/visit	Same as network benefit	Ancillary services may be subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Authorization required. Transplants must be at Designated Facilities.
	Physician/surgeon fee	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit 20% coinsurance for ABA services	Not covered	Authorization required for non-routine services.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	Authorization required.
	Substance use disorder outpatient services	$25 copay/visit	Not covered	Authorization required for non-routine services.
	Substance use disorder inpatient services	20% coinsurance	Not covered	Authorization required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	Certain prenatal tests are covered with no member cost share when using network providers.
	Delivery and all inpatient services	20% coinsurance	Not covered	Authorization required if inpatient stay exceeds federally established minimum time frames.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Authorization required.
	Rehabilitation services	20% coinsurance	Not covered	Calendar year maximums: outpatient speech therapy – 30 visits; outpatient physical therapy, occupational therapy and spinal treatment – 30 visits; pulmonary and cardiac rehabilitation therapy – 30 visits. Authorization required for all services except spinal treatment.
	Habilitation services	20% coinsurance	Not covered	Calendar year maximums: outpatient speech therapy – 30 visits; outpatient physical therapy and occupational therapy – 30 visits. Authorization required for some services. Call PHP to verify coverage. Services for treatment of autism are not included in above limits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	20% coinsurance	Not covered	Combined limit for skilled nursing facility and hospice facility care of 45 days per calendar year. Authorization required.
	Durable medical equipment	20% coinsurance	Not covered	Authorization required on certain items of DME. Call PHP for current information.
	Hospice service	20% coinsurance	Not covered	Combined limit for skilled nursing facility and hospice facility care of 45 days per calendar year. Authorization required.
If your child needs dental or eye care	Eye exam	No charge	Not covered	This is a preventive service. Limited to 1 routine exam per calendar year.
	Glasses	20% coinsurance	Not covered	Limited to 1 pair of glasses per calendar year. Other limitations may apply.
	Dental check-up	Not covered	Not covered	This plan has no coverage for this service.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Elective abortion
- Experimental or investigational procedures and services
- Hearing aids
- Infertility treatment to conceive pregnancy
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot care
- Services that are not medically necessary as determined by PHP medical policy and national guidelines

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**		
• Bariatric surgery if meet criteria-20% coinsurance, network only	• Chiropractic care-20% coinsurance, to combined limit of 30 visits per calendar [policy] year (limit combined with other outpatient rehabilitation therapies), network only	• Infertility treatment to treat the conditions that result in infertility only-20% coinsurance, network only • Weight loss programs if meet criteria-20% coinsurance, network only

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at 1-800-832-9186 or 517-364-8500 locally. You may also contact your state insurance department at 1-877-999-6442 or 517-373-0220 locally or www.michigan.gov/difs.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-800-832-9186 or 517-364-8500 locally.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,190
- **Patient pays** $1,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$750
Copays	$0
Coinsurance	$450
Limits or exclusions	$150
Total	**$1,350**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,103
- **Patient pays** $1,297

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$268
Copays	$932
Coinsurance	$0
Limits or exclusions	$97
Total	**$1,297**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.