|  |  |
| --- | --- |
|  | **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**. |

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| **Important Questions** | **Answers** | **Why this Matters:** |
| **What is the overall deductible?** | **$250** individual **/ $500** family  Does not apply to copays and preventive care. | You must pay all the costs up to the **deductible** amount before thisplan 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. **$1,000** individual **/ $2,000** 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**. |

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|  | * **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 | $20 copay/visit | Not covered | Ancillary services may be subject to deductible and coinsurance. |
| Specialist visit | $35 copay/visit | Not covered | Ancillary services may be subject to deductible and coinsurance. |
| Other practitioner office visit | 10% 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) | 10% coinsurance | Not covered |  |
| Imaging (CT/PET scans, MRIs) | 10% coinsurance | Not covered |  |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at [www.express-scripts.com](http://www.express-scripts.com). | Tier 1 drugs (mostly generic) | $10 copay/prescription (retail)  $20 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 available from mail-order service.  Some drugs require authorization. Call PHP for more information. |
| Tier 2 drugs (mostly Preferred brand name) | $40 copay/prescription (retail)  $80 copay/prescription (mail order) | Only covered for emergent/urgent condition. |
| 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) | 10% coinsurance | Not covered | Female sterilization is covered at no member cost share when using network providers.  Authorization required for reconstructive procedures. |
| Physician/surgeon fees | 10% 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 | $150 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 | 10% 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) | 10% coinsurance | Not covered | Authorization required. Transplants must be at Designated Facilities. |
| Physician/surgeon fee | 10% coinsurance | Not covered |  |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $20 copay/visit  10% coinsurance for ABA services | Not covered | Authorization required for non-routine services. |
| Mental/Behavioral health inpatient services | 10% coinsurance | Not covered | Authorization required. |
| Substance use disorder outpatient services | $20 copay/visit | Not covered | Authorization required for non-routine services. |
| Substance use disorder inpatient services | 10% coinsurance | Not covered | Authorization required. |
| **If you are pregnant** | Prenatal and postnatal care | 10% coinsurance | Not covered | Certain prenatal tests are covered with no member cost share when using network providers. |
| Delivery and all inpatient services | 10% 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 | 10% coinsurance | Not covered | Authorization required. |
| Rehabilitation services | 10% 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 | 10% 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. |
| Skilled nursing care | 10% coinsurance | Not covered | Combined limit for skilled nursing facility and hospice facility care of 45 days per calendar year. Authorization required. |
| Durable medical equipment | 10% coinsurance | Not covered | Authorization required on certain items of DME. Call PHP for current information. |
| Hospice service | 10% 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 | 10% 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-10% coinsurance, network only | * Chiropractic care-10% coinsurance, to combined limit of 30 visits per calendar year (limit combined with other outpatient rehabilitation therapies), network only | * Infertility treatment to treat the conditions that result in infertility only-10% coinsurance, network only * Weight loss programs if meet criteria-10% 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 517-364-8500locally. You may also contact your state insurance department at 1-877-999-6442 or 517-373-0220 locally or [www.michigan.gov/difs](http://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 517-364-8500locally.

**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.–––––––––––*–––––––––––

**Managing type 2 diabetes**(routine maintenance of

a well-controlled condition)

**Having a baby**(normal delivery)

**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.



◼ **Amount owed to providers:** $7,540

◼ **Plan pays** $6,438

◼ **Patient pays** $1,102

**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 | $250 |
| Copays | $15 |
| Coinsurance | $687 |
| Limits or exclusions | $150 |
| **Total** | **$1,102** |

◼ **Amount owed to providers:** $5,400

◼ **Plan pays** $4,303

◼ **Patient pays** $1,097

**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 | $250 |
| Copays | $734 |
| Coinsurance | $0 |
| Limits or exclusions | $97 |
| **Total** | **$1,097** |

**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 planprovides.

**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.