Benefit Summary
Gold 2,000 - PPO

PHP Insurance Company

Medical Product: GFH018

Pharmacy Product: RX03F362

TYPE OF BENEFITS	NETWORK		NON-NETWORK	
ANNUAL DEDUCTIBLE	$2,000	Individual	$5,000	Individual
	$4,000	Family	$10,000	Family
COINSURANCE (Member responsibility after deductible)	20%		40%	
COINSURANCE MAXIMUM	$1,500	Individual	N/A	Individual
	$3,000	Family	N/A	Family
ANNUAL OUT-OF-POCKET MAXIMUM (Includes deductible, coinsurance, copays)	$8,000	Individual	$15,000	Individual
	$16,000	Family	$30,000	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 (PCP,OB/GYN, Behavorial Health)		$25 copay - ded waived	40% - after ded
Specialist		$50 copay - ded waived	
• Injections/Infusions		20% - after ded	
• Allergy injections			
• Associated services			
PREVENTIVE SERVICES - ***Including but not limited to:***		**NETWORK**	**NON-NETWORK**
• Physicial exam - annual routine	• Tobacco cessation program	0% - ded waived	Not Covered
• Well baby/well child care	• Immunizations		
• Laboratory services - routine	• Pap smears		
• Nutritional counseling - prev.	• Mammography - screening		
INPATIENT HOSPITAL		**NETWORK**	**NON-NETWORK**
• Surgery		20% - after ded	40% - after ded
• Semi-Private Room/Special Care Unit (Unlimited days)			
• Anesthesia - including administration			
• Physician services - including consultation			
• Necessary ancillary hospital services			
SPECIAL SURGERIES/SERVICES		**NETWORK**	**NON-NETWORK**
• Reduction Mammoplasty, Orthognathic/TMJ, Male Mastectomy		50% - after ded	Not Covered
• Bariatric/Weight Mgt Programs	Limit: 1 Surgery/Lifetime		
OUTPATIENT SERVICES		**NETWORK**	**NON-NETWORK**
• X-ray, Tests and Procedures - diagnostic		20% - after ded	40% - after ded
• Laboratory/Pathology - diagnostic			
• OP Surgery (all other)			
• Advanced Diagnostic Imaging/High Tech Radiology/Nuclear Med		$150 copay - after ded	
• Chiropractic services	Limit: 30 visits/CY	$30 copay - after ded	
Outpatient Rehabilitation Therapy:			
• Physical	Limit: 30 visits combined with OT/CY	$50 copay - after ded	40% - after ded
• Occupational	Limit: 30 visits combined with PT/CY		
• Speech	Limit: 30 visits/CY		
• Pulmonary	Limit: 30 visits combined with Cardiac/CY		
• Cardiac	Limit: 30 visits combined with Pulm/CY		
EMERGENCY/URGENT SERVICES		**NETWORK**	**NON-NETWORK**
Emergency Services:			
• Emergency Department (copay waived if admitted inpatient)		20% - after ded	Covered as Network benefit
• Associated services		20% - after ded	
• Ambulance services		20% - after ded	
Urgent Care Services:			
• Facility		$60 copay - ded waived	Covered as Network benefit
• Associated services		20% - after ded	
• Convenience Care Facility (ex. Sparrow FastCare)		$25 copay - ded waived	40% - after ded
• Telehealth - Amwell Acute Care		$5 copay - ded waived	N/A

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BEHAVIORAL HEALTH SERVICES	NETWORK	NON-NETWORK
• Therapy visits and testing - outpatient	$25 copay - ded waived	40% - after ded
• Inpatient treatment - including detoxification	20% - after ded	
• Residential treatment program/Intermediate treatment		
• All other outpatient services		
• Telehealth - Amwell Behavioral Health	$25 copay - ded waived	N/A

OTHER SERVICES		NETWORK	NON-NETWORK
• Durable Medical Equipment (DME)/Prosthetic Devices		50% - ded waived	Not Covered
• Home Health Care	Limit: 60 visits/CY	20% - after ded	40% - after ded
• Hospice - Facility	Limit: 45 days combined with SNF & IP Rehab Facility/CY		
• Hospice - Home	No Limit		
• Skilled Nursing Facility	Limit: 45 days combined with Hospice Facility & IP Rehab Facility/CY		
• IP Rehab Facility	Limit: 45 days combined with Hospice Facility & SNF/CY		
• Surgical Sterilization - Female		0% - ded waived	
• Surgical Sterilization - Male		20% - after ded	
• Infertility treatment (to treat the underlying conditions that result in infertility)		Covered as any other medical condition	
• Pediatric Vision Services (limitations apply) Routine vision exam		0% - ded waived	Not Covered
• Eyewear, contacts, other services		20% - after ded	

PHARMACY BENEFITS	NETWORK	NON-NETWORK
***Outpatient prescription drugs:**		
• Tier 1 - (up to 31-day supply)	$20 copay - ded waived	Not Covered
• Tier 2 - (up to 31-day supply)	$50 copay - ded waived	
• Tier 3 - (up to 31-day supply)	$80 copay - ded waived	
• Tier 4 - (up to 31-day supply)	20% - ded waived	
	$300 Max	
• 90-day supply	2 copays	
• Specialty Medications (up to 31-day supply)	CVS mail-order only	
• Select Prescription Drugs for ACA Mandated Preventive Coverage Only	No Charge	

*Ancillary Charge (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 plus the difference between the cost of the brand-name drug and the generic drug (not to exceed the retail cost of the brand-name drug).

Associated Services: Charges for diagnostic or supportive services (ex. Lab/Path, Radiology, Facility/Professional Fees, Medical Supplies)

Certain covered health services must be authorized in advance by PHP Insurance Company. The phone number to call to request authorization is on the member ID card. Covered Health Services must be Medically Necessary as determined by PHP Insurance Company 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. Except as may be specifically provided through a Rider to the policy, Exclusions include:

- Experimental or investigational procedures or services
- Custodial care, bed care, convenience care, day care, domiciliary care
- Hearing aids and services
- Adult vision exam and hardware
- Routine dental care
- Cosmetic surgery
- Fertility medications
- 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. Please refer to your Certificate of Coverage for a complete listing of covered services, limitations and Exclusions and a description of all the terms and conditions of coverage. 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. *1/20*