



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 www.healthcare.gov/sbc-glossary 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 deductible ?	\$1,000 Individual / \$2,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care and other services as noted are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.alwayshealthpartners.org .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$8,000 Individual / \$16,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
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 .
Will you pay less if you use a network provider ?	Yes. See www.phpmichigan.com or call 1.866.539.3342 or 517.364.8567 locally for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the network specialist you choose without a referral .



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

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)	
If you visit a health care provider's office or clinic	Primary Care visit to treat an injury or illness.	\$30 copay per visit, Deductible does not apply Subject to deductible , then 20% coinsurance for associated services	Not covered Not covered	Convenience care facilities are covered under this benefit.
	Specialist visit	\$50 copay per visit, Deductible does not apply Subject to deductible , then 20% coinsurance for associated services	Not covered Not covered	Allergy services (not including injections) are covered at 50% coinsurance after deductible from network providers only.
	Preventive care/screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray)	Subject to deductible , then 20% coinsurance	Not covered	None
	Diagnostic test (blood work)	Subject to deductible , then 20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	Subject to deductible , then \$150 copay per procedure	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.caremark.com/wps/portal .	Preferred generic and select brand-name drugs to treat certain chronic conditions (Tier 1A) Other preferred generic drugs (Tier 1B)	1A: \$5 copay per prescription, Deductible does not apply (retail) 1B: \$20 copay per prescription, Deductible does not apply (retail) 1A: \$10 copay per prescription, Deductible does not apply (mail	1A: Not covered (retail) 1B: Not covered (retail) 1A: Not covered (mail order) 1B: Not covered (mail order)	Covers up to a 31-day supply (retail prescription); 32-90-day supply (mail order prescription). ACA mandated preventive drugs such as select contraceptive and tobacco cessation medications are covered with no member cost share.

* For more information about limitations and exceptions, see the certificate of coverage at 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)	
		order) 1B: \$40 copay per prescription, Deductible does not apply (mail order)		Preferred Tobacco Cessation Products are only available from retail network pharmacies in up to 31-day supply. All Specialty Drugs regardless of tier placement are only available from CVS mail-order specialty pharmacy in up to a 31-day supply. Tier 1A drugs are available from a retail network pharmacy in up to a 90-day supply. If a brand-name drug has a generic drug that is chemically the same, you pay your applicable copay or coinsurance amount plus the difference between the brand-name and generic price. Some drugs require prior approval for coverage. Call us for more information.
	Preferred brand-name drugs (Tier 2)	\$60 copay per prescription, Deductible does not apply (retail) \$120 copay per prescription, Deductible does not apply (mail order)	Not covered (retail) Not covered (mail order)	
	Non-preferred brand drugs (Tier 3)	\$80 copay per prescription, Deductible does not apply (retail) \$160 copay per prescription, Deductible does not apply (mail order)	Not covered (retail) Not covered (mail order)	
	Preferred Specialty drugs (Tier 4)	Not covered (retail) 20% coinsurance , Deductible does not apply (mail order)	Not covered (retail) Not covered (mail order)	
	Non-Preferred Specialty drugs (Tier 5)	Not covered (retail) 40% coinsurance , Deductible does not apply (mail order)	Not covered (retail) Not covered (mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Subject to deductible , then 20% coinsurance	Not covered	Prior approval required for coverage of certain surgeries. Call us for the complete list.
	Physician/surgeon fees	Subject to deductible , then 20% coinsurance	Not covered	Prior approval required for coverage of certain surgeries. Call us for the complete list.

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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)	
If you need immediate medical attention	Emergency room care	Subject to deductible , then 20% coinsurance Subject to deductible , then 20% coinsurance for associated services	Subject to deductible , then 20% coinsurance Subject to deductible , then 20% coinsurance for associated services	Prior approval is required for coverage if admitted from the Emergency Department for an inpatient stay.
	Emergency medical transportation	Subject to deductible , then 20% coinsurance	Subject to deductible , then 20% coinsurance	
	Urgent care	\$75 copay per visit, Deductible does not apply Subject to deductible , then 20% coinsurance for associated services	\$75 copay per visit, Deductible does not apply Subject to deductible , then 20% coinsurance for associated services	
If you have a hospital stay	Facility fee (e.g., hospital room)	Subject to deductible , then 20% coinsurance	Not covered	Prior approval required for coverage of inpatient stays. Transplants must be at Designated Facilities.
	Physician/surgeon fees	Subject to deductible , then 20% coinsurance	Not covered	Prior approval required for coverage of inpatient stays.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay per visit, Deductible does not apply	Not covered	Prior approval required for coverage of non-routine services, including ABA services and inpatient stays.
	Inpatient services	Subject to deductible , then 20% coinsurance	Not covered	Prior approval required for coverage of non-routine services, including ABA services and inpatient stays.
If you are pregnant	Office visits	Included in professional services below	Included in professional services below	Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prior approval required for coverage if inpatient stay exceeds federally established minimum time frames. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	Subject to deductible , then 20% coinsurance	Not covered	
	Childbirth/delivery facility services	Subject to deductible , then 20% coinsurance	Not covered	
	Home health care	Subject to deductible , then 20% coinsurance	Not covered	Prior approval required for coverage.

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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)	
If you need help recovering or have other special health needs	Rehabilitation services	Subject to deductible , then \$50 copay per visit	Not covered	Covered services for treatment of autism are not included in below limits. Prior approval required for coverage of outpatient physical, occupational and speech therapy. Outpatient Speech Therapy Limit: Limit for ST of 30 visit(s) per calendar year. Outpatient Pulmonary and Cardiac Therapy Limit: Combined limit for cardiac/pulmonary of 30 visit(s) per calendar year. Outpatient Physical and Occupational Therapy Limit: Combined limit for PT/OT of 30 visit(s) per calendar year.
	Habilitation services	Subject to deductible , then \$50 copay per visit	Not covered	
	Skilled nursing care	Subject to deductible , then 20% coinsurance	Not covered	
	Durable medical equipment	50% coinsurance , Deductible does not apply	Not covered	
	Hospice services	Subject to deductible , then 20% coinsurance	Not covered	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	This is a preventive service. Routine Eye Exam for Children Limit: limit of 1 exam(s) per calendar year.
	Children's glasses	Subject to deductible , then 20% coinsurance	Not covered	Other limitations apply. Lenses for Children Limit: limit of 1 pair(s) per calendar year.
	Children's dental check-up	Not covered	Not covered	This plan has no coverage for this service.

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"> Acupuncture Cosmetic Surgery 	<ul style="list-style-type: none"> Elective abortion as defined by the State of Michigan Hearing aids and services 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Routine eye care (adult)

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Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
• Dental Care	• Infertility treatment and medications to conceive a pregnancy	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Infertility treatment to treat the underlying conditions that result in infertility only	• Weight loss services, including qualified programs
• Chiropractic care		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Michigan Department of Insurance & Financial Services (DIFS), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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. 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 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. You may also contact the Michigan Department of Insurance & Financial Services (DIFS), the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage?

Not Applicable.

Does this plan meet the Minimum Value Standards?

Not Applicable.

Physicians Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. PHP provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats, other formats); and provides free language services to people whose primary language is not English, such as qualified interpreters; and information written in other languages. If you need these services, contact Customer Service at 800.832.8186 (TTY 711). If you believe that PHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the PHP Civil Rights Coordinator, mailing address: PO Box 30377 Lansing MI 48909-7877, phone: 800.832.9186, (TTY 711), fax: 517.364.8406 email: phpcompliance@phpmm.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the PHP Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1.800.368.1019, 800.537.7697 (TTD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

* For more information about limitations and exceptions, see the certificate of coverage at www.phpmichigan.com.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$1,000	■ The plan's overall deductible	\$1,000	■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$50	■ Specialist copayment	\$50	■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,000	Deductibles*	\$400	Deductibles*	\$1,000
Copayments	\$10	Copayments	\$1,600	Copayments	\$300
Coinsurance	\$2,300	Coinsurance	\$0	Coinsurance	\$300
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$50	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$3,360	The total Joe would pay is	\$2,020	The total Mia would pay is	\$1,600

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.