Coverage for: Individual or Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>Member Reference Desk</u> or by calling 1.866.539.3342 or 517.364.8567 locally. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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 <u>deductible</u> ? | \$4,000 Individual / \$8,000 Family | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. Preventive care and other services as noted are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.allwayshealthpartners.org</u> . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$8,500 Individual / \$17,000 Family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | 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 <u>network provider</u> ? | Yes. See <u>www.phpmichigan.com</u> or call 1.866.539.3342 or 517.364.8567 locally for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the network specialist you choose without a referral. |



| | | What You | u Will Pay | Limitations, Exceptions, & Other Important Information | |
|--|--|--|--|---|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | | |
| | Primary Care visit to treat an injury or illness. | \$50 <u>copay</u> per visit, <u>deductible</u> does not apply Subject to <u>deductible</u> , then 40% <u>coinsurance</u> for associated services | Not covered Not covered | Convenience care facilities are covered under this benefit. | |
| If you visit a health care provider's office or clinic | <u>Specialist</u> visit | \$80 <u>copay</u> per visit, <u>deductible</u> does not apply Subject to <u>deductible</u> , then 40% <u>coinsurance</u> 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 <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. | |
| | Diagnostic test (x-ray) | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | None. | |
| If you have a test | Diagnostic test (blood work) | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | None. | |
| | Imaging (CT/PET scans, MRIs) | Subject to <u>deductible</u> , then \$150 <u>copay</u> 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: \$10 <u>copay</u> per prescription, <u>deductible</u> does not apply (retail) 1B: \$30 <u>copay</u> per prescription, <u>deductible</u> does not apply (retail) 1A: \$20 <u>copay</u> per prescription, <u>deductible</u> 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. | |

| | | What You | u Will Pay | Limitations, Exceptions, & Other Important | |
|-----------------------------------|--|---|--|---|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | Information | |
| | | order) 1B: \$60 <u>copay</u> per prescription, <u>deductible</u> 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- | |
| | Preferred brand-name drugs (Tier 2) | \$80 <u>copay</u> per prescription, <u>deductible</u> does not apply (retail) \$160 <u>copay</u> per prescription, <u>deductible</u> does not apply (mail order) | Not covered (retail) Not covered (mail order) | 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 | |
| | Non-preferred brand drugs (Tier 3) | \$200 <u>copay</u> per prescription, <u>deductible</u> does not apply (retail) \$400 <u>copay</u> per prescription, <u>deductible</u> does not apply (mail order) | Not covered (retail) Not covered (mail order) | the difference between the brand-name and generic price. Some drugs require prior approval for coverage. Call us for more information. | |
| | Preferred Specialty drugs (Tier 4) | Not covered (retail) 20% <u>coinsurance</u> , <u>deductible</u> does not apply (mail order) | Not covered (retail) Not covered (mail order) | | |
| | Non-Preferred Specialty drugs (Tier 5) | Not covered (retail) 40% <u>coinsurance</u> , <u>deductible</u> does not apply (mail order) | Not covered (retail) Not covered (mail order) | | |
| lf you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Subject to <u>deductible,</u> then 40% <u>coinsurance</u> | Not covered | Female sterilization is covered at no member cost share when using network providers. Prior approval required for coverage of certain surgeries. Call us for the complete list. | |
| | Physician/surgeon fees | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | Female sterilization is covered at no member cost share when using network providers. Prior approval required for coverage of certain surgeries. Call us for the complete list. | |

| | | What You | u Will Pay | Limitations, Exceptions, & Other Important | |
|--|--|---|---|--|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | Information | |
| | Emergency room care | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> Subject to <u>deductible</u> , then 40% <u>coinsurance</u> for associated services | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> Subject to <u>deductible</u> , then 40% <u>coinsurance</u> for associated services | | |
| If you need immediate medical attention | Emergency medical transportation | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Prior approval is required for coverage if admitted from the Emergency Department for | |
| | <u>Urgent care</u> | \$85 <u>copay</u> per visit, <u>deductible</u> does not apply Subject to <u>deductible</u> , then 40% <u>coinsurance</u> for associated services | \$85 <u>copay</u> per visit, <u>deductible</u> does not apply Subject to <u>deductible</u> , then 40% <u>coinsurance</u> for associated services | an inpatient stay. | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | Prior approval required for coverage of inpatient stays. Transplants must be at Designated Facilities. | |
| | Physician/surgeon fees | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | Prior approval required for coverage of inpatient stays. | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$50 <u>copay</u> per visit, <u>deductible</u> does not apply | Not covered | Prior approval required for coverage of non- routine services, including ABA services and inpatient stays. | |
| | Inpatient services | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | 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 <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | | |
| | Childbirth/delivery facility services | Subject to <u>deductible,</u> then 40% <u>coinsurance</u> | Not covered | | |
| | Home health care | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | Prior approval required for coverage. | |

| | | What You Will Pay | | Limitations, Exceptions, & Other Important | |
|--|----------------------------|--|---|--|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | Information | |
| If you need help recovering or have other | Rehabilitation services | Subject to <u>deductible</u> , then \$80 <u>copay</u> per visit | Not covered | Covered services for treatment of autism are not included in below limits. | |
| special health needs | Habilitation services | Subject to <u>deductible,</u> then \$80 <u>copay</u> per visit | Not covered | Prior approval required for coverage of outpatient 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 Therap Limit: Combined limit for PT/OT of 30 visit(s) per calendar year. | |
| | Skilled nursing care | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | Prior approval required for coverage. Limit of 45 day(s) per calendar year. | |
| | Durable medical equipment | 50% <u>coinsurance</u> , <u>deductible</u> does not apply | Not covered | Prior approval required for coverage of certain items of DME. Call us for current information. | |
| | Hospice services | Subject to <u>deductible</u> , then 40% <u>coinsurance</u> | Not covered | Limit of 45 day(s) per calendar year. | |
| 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 <u>deductible</u> , then 40% <u>coinsurance</u> | 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. | |

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | | | | |
|--|---|---|--|--|--|
| Acupuncture | Elective abortion as defined by the State of | Non-emergency care when traveling outside the | | | |
| Cosmetic Surgery | Michigan | U.S. | | | |
| Dental Care | Hearing aids and services | Routine eye care (adult) | | | |
| | Infertility treatment and medications to conceive a | Routine foot care | | | |
| | pregnancy | | | | |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | | | | |
| Bariatric surgery | Covered services through the Indian Health | Weight loss services, including qualified programs | | | |
| Chiropractic care | Service, and Indian Tribe, Tribal Organization, or | Gender affirming care | | | |

 Infertility treatment to treat the underlying conditions that result in infertility only

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.

Urban Indian Organization, or through referral

under contract health services-no charge.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 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.

Language Access Services: If you, or someone you are helping, has questions about this 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 (TTY 711).

Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de PHP, tiene derecho a obtener ayuda e información en su idiorna sin costo alguno. Para hablar con un intérprete, llame al 517.364.8500 - 800.832.9186 (TTY 711). Arabic

> -إن كان الديك-أو الدى شخص قساعده أسئلة بخصوص PHP، فلديك الحق في الحصول على المساعدة والمعلومات الض رورية بلغتك من دون اية تكلفة المتحدث مع مترجع اتسل بـ 800.832.9186-- 800.832.917 (TTY-711) ، ¶

Chinese 如果您, 或是您正在協助的對象, 有關於[插入SBM 項目的名稱冊方面的問題, 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 (TTY 711).

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 (TTY 711) an.

Italian Seitu 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 (TTY 711).

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 (TTY 711) までお電話ください。 Korean 만약 귀하또는 귀하가 돕고 있는 어떤사람이 PHP에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의언어로 비용부담없이

얻을 수있는 권리가있습니다. 그렇게 통역사와 얘기하기 위해서는517.364.8500 - 800.832.9186 (TTY711) 로 전화하십시오.

Polish Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie PHP, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku . Aby porozmawiać z tłumaczem, zadzwoń pod numer 517.364.8500 - 800.832.9186 (TTY 711).

Russian Если у вас или лица, которому вы помогаете, имеются вопросы по поводу PHP, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 517.364.8500 - 800.832.9186 (TTY 711). Syriac

Tagalog Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa PHP, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 517.364.8500 - 800.832.9186 (TTY 711).

Vietnamese Nếu quý vị, hay người mà quý vị đang giúp đờ, có câu hỏi về PHP, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 517.364.8500 - 800.832.9186 (TTY 711).

Bengali যদি আপদি, 517.364.8500 - 800.832.9186 আপদি অিয কাউকক সহায়তা করকেি, সম্পকক**ে প্রশ্ন আকে PHP, আপিার অদিকার আকে দবি**া খরকে আপিার দিজস্ব ভাষাকত সাহাযয পাবার এবং তথয জা**িবার। তিবুবা**িককর সাকথ কথা বলার জিয়, কল করুি 517.364.8500 - 800.832.9186 (TTY 711).

Albanian Nëse ju, ose dikush që po ndihmoni, ka pyetje për PHP, keni të drejtë të mermi ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 517.364.8500 - 800.832.9186 (TTY 711).

Serbo-Croatian Ukoliko Vi ili neko kome Vi pomažete ima pitanje o PHP, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, na zovite 517.364.8500 - 800.832.9186 (TTY 711).

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. 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 B (9 months of in-network pre-natal c 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\$4,000Specialist copayment\$80Hospital (facility) coinsurance40%Other coinsurance40% | | The <u>plan's</u> overall <u>deductible</u> Specialist <u>copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> | \$4,000 \$80 40% 40% | The <u>plan's</u> overall <u>deductible</u> Specialist <u>copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> | | |
| This EXAMPLE event includes see Specialist office visits (<i>prenatal care</i> Childbirth/Delivery Professional See Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and b</i> Specialist visit (<i>anesthesia</i>) | e) rvices | This EXAMPLE event includes services like:Primary care physician office visits (including disease education)Diagnostic tests (blood work)Prescription drugsDurable medical equipment (glucose meter) | | 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> | | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,500 | Total Example Cost | \$2,800 | |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | | |
| Cost Sharing | | Cost Sharing Cost | | Cost Sharing | Sharing | |
| Deductibles | \$4,000 | Deductibles* | \$400 | Deductibles* | \$2,300 | |
| Copayments | \$10 | Copayments | \$1,800 | Copayments | \$200 | |
| Coinsurance | \$3,400 | Coinsurance | \$0 | Coinsurance \$1 | | |
| What isn't covered | | What isn't covered | | What isn't covered | | |
| Limits or exclusions | \$50 | Limits or exclusions \$0 | | Limits or exclusions | \$0 | |
| The total Peg would pay is | \$7,460 | The total Joe would pay is | \$2,200 | The total Mia would pay is | \$2,600 | |

The plan would be responsible for the other costs of these EXAMPLE covered services.