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?	$150 Individual / $300 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.healthcare.gov/coverage/preventive-care-benefits/.
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?	$1,100 Individual / $2,200 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, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and any co-pays and co-insurance you pay for any non-essential health benefits.	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.

Important Questions	Answers	Why This Matters:
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.	$5 copay per visit, deductible does not apply	Not covered	Associated services will apply to the plan deductible and coinsurance. Convenience care facilities are covered under this benefit.
	Specialist visit	$15 copay per visit, deductible does not apply	Not covered	Associated services will apply to the plan deductible and coinsurance. 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/blood work)	10% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	$150 copay per procedure after deductible	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)	$5 copay per prescription (retail) $10 copay per prescription (mail order)	Only covered for emergent/urgent condition	Deductible does not apply to copays or coinsurance amounts for outpatient prescription drugs. 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. Preferred Tobacco Cessation Products are only available from retail network pharmacies in up to 31-day supply.
	Other generic drugs (Tier 1B)	$15 copay per prescription (retail) $30 copay per prescription (mail order)	Only covered for emergent/urgent condition	
	Preferred brand-name drugs (Tier 2)	$40 copay per prescription (retail) $80 copay per prescription (mail order)	Only covered for emergent/urgent condition	

* 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)	
	Non-preferred brand drugs (Tier 3)	$80 copay per prescription (retail) $160 copay per prescription (mail order)	Only covered for emergent/urgent condition	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 PHP for more information.
	Preferred Specialty drugs (Tier 4)	Not covered (retail) 20% coinsurance (mail order)	Not covered	
	Non-Preferred Specialty drugs (Tier 5)	Not covered (retail) 40% coinsurance (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	Female sterilization is covered at no member cost share when using network providers. Prior approval required for coverage of certain surgeries. Call PHP for the complete list.
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Female sterilization is covered at no member cost share when using network providers. Prior approval required for coverage of certain surgeries. Call PHP for the complete list.
If you need immediate medical attention	Emergency room care	10% coinsurance after deductible	10% coinsurance after deductible	Associated services will apply to the plan deductible and coinsurance. Prior approval is required for coverage if admitted from the Emergency Department for an inpatient stay.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	
	Urgent care	$50 copay per visit, deductible does not apply	$50 copay per visit, deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Prior approval required for coverage of inpatient stays. Transplants must be at Designated Facilities.
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Prior approval required for coverage of inpatient stays.

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 mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay per visit, deductible does not apply	Not covered	Prior approval required for coverage of non-routine services, including ABA services and inpatient stays. ABA services will apply to the plan deductible and coinsurance.
	Inpatient services	10% coinsurance after deductible	Not covered	Prior approval required for coverage of non-routine services, including ABA services and inpatient stays.
If you are pregnant	Prenatal and Postnatal office visits	No charge	Not covered	Cost sharing does not apply for preventive services. 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.
	Childbirth/delivery professional services	10% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not covered	Prior approval required for coverage.
	Rehabilitation services	$15 copay per visit after deductible	Not covered	There are separate limits for rehabilitative and habilitative services: PT & OT = 30 visits per calendar year; ST = 30 visits per calendar year; and cardiac & pulmonary rehab = 30 visits per calendar year. Covered services for treatment of autism are not included in above limits. Prior approval required for coverage of outpatient speech therapy.
	Habilitation services	$15 copay per visit after deductible	Not covered	
	Skilled nursing care	10% coinsurance after deductible	Not covered	Prior approval required for coverage. Limit of 45 day(s) per calendar year
	Durable medical equipment	50% coinsurance, deductible does not apply	Not covered	Prior approval required for coverage of certain items of DME. Call PHP for current information.
	Hospice services	10% coinsurance after deductible	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

* 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)	
	Children's glasses	10% coinsurance after deductible	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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Elective abortion as defined by the State of Michigan
- Hearing aids and services
- Infertility treatment and medications to conceive a pregnancy
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- 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
- Chiropractic care
- Infertility treatment to treat the underlying conditions that result in infertility only
- Weight loss services, including bariatric surgery and programs

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

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.

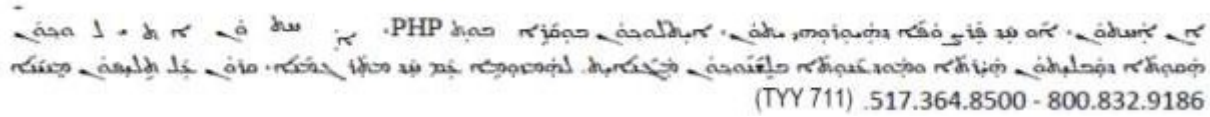
Non-Discrimination:
Physicians Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHP does not exclude people or treat them differently because of race, color, national origin, age, disability, 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.
Language Access Services: If you, or someone you are helping, has questions about this Benefit 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 idioma sin costo alguno. Para hablar con un intérprete, llame al 517.364.8500 - 800.832.9186 (TTY 711).
Arabic

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص PHP، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 517.364.8500 - 800.832.9186 (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PHP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

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

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 Se tu 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 귀하 또는 귀하가돕고있는 어떤 사람이 PHP에 관해서질문이있다면귀하는 그러한 도움과정보를 귀하의 언어로비용부담없이 얻을수 있는 권리가있습니다. 그렇게통역사와얘기하기 위해서는517.364.8500 - 800.832.9186 (TTY 711) 로전화하십시오.
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 đỡ, 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 দিয কাউকক সহায়তা করককদ , সম্পককক প্রশ্ন আকক PHP, আদপার িদকার আকক িদ াখরকক আদপার দিজস্ব ভাষাকত সাহাযয পা ার এ ং তথয জাদ ার। দি ু াদ ককর সাকথ কথা লার জজয, কল করুদ 517.364.8500 - 800.832.9186 (TTY 711).
Albanian Nëse ju, ose dikush që po ndihmoni, ka pyetje për PHP, keni të drejtë të merrni 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, nazovite 517.364.8500 - 800.832.9186 (TTY 711).

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

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)

The plan's overall deductible	$150
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$1,150**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$150
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$800
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$980**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$150
Specialist copayment	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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