




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 <https://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 ? | \$8,550 individual / \$17,100 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 is covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the 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 ? | \$8,550 individual / \$17,100 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 limits 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 1.800.832.9186 or 517.364.8500 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 | First 3 visits in a policy year: no charge After first 3 visits: No charge after deductible | Not covered | Convenience care facilities such as FastCare are covered under this benefit. |
| | Specialist visit | No charge after deductible | Not covered | None. |
| | 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 you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge after deductible | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | No charge after deductible | Not covered | |
| 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 drugs to treat chronic conditions (Tier 1A) Other generic drugs (Tier 1B) | No charge after deductible (retail mail-order) | Not covered | Covers up to a 31-day supply (retail prescription); 32-90-day supply (mail order or retail 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. All Specialty Drugs regardless of tier placement are only available from CVS mail-order pharmacy in up to 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 |
| | Preferred brand drugs (Tier 2) | No charge after deductible (retail mail-order) | Not covered | |
| | Non-preferred brand drugs (Tier 3) | No charge after deductible (retail mail-order) | Not covered | |
| | Preferred Specialty drugs (Tier 4) | Not available (retail) No charge after deductible (mail-order) | Not covered | |
| | Non-Preferred Specialty drugs (Tier 5) | Not available (retail) No charge after deductible (mail-order) | Not covered | |

* 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) | |
| | | | | applicable cost share plus the difference between the brand-name and generic price. Some drugs require prior approval for coverage. Call PHP Insurance Company for more information. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge 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 | No charge 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 department care | No charge after deductible | Same as network benefit | Prior approval is required for coverage if admitted from the Emergency Department for an inpatient stay. |
| | Emergency medical transportation | No charge after deductible | Same as network benefit | |
| | Urgent care | No charge after deductible | Same as network benefit | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge after deductible | Not covered | Prior approval required for coverage of inpatient stays. Transplants must be at Designated Facilities. |
| | Physician/surgeon fees | No charge after deductible | Not covered | Prior approval required for coverage of inpatient stays. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge after deductible | Not covered | Prior approval required for coverage of non-routine services, including ABA services and inpatient stays. |
| | Inpatient services | No charge after deductible | Not covered | |
| If you are pregnant | Office visits | Included in professional services below | 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 |
| | Childbirth/delivery professional services | No charge after deductible | Not covered | |
| | Childbirth/delivery facility | No charge after | Not covered | |

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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) | |
| | services | deductible | | stay exceeds federally established minimum time frames. |
| If you need help recovering or have other special health needs | Home health care | No charge after deductible | Not covered | Prior approval required for coverage. |
| | Rehabilitation services | No charge 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 physical, occupational and speech therapy. |
| | Habilitation services | No charge after deductible | Not covered | |
| | Skilled nursing care | No charge after deductible | Not covered | |
| | Durable medical equipment | No charge after deductible | Not covered | Prior approval required for coverage of certain items of DME. Call PHP for current information. |
| | Hospice services | No charge after deductible | Not covered | Combined limit for skilled nursing facility, inpatient rehabilitation facility and hospice facility care of 45 days per calendar year. Prior approval required for coverage. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | This is a preventive service. Limited to 1 routine exam per calendar year. |
| | Children's glasses | No charge after deductible | Not covered | Limited to 1 pair of glasses per calendar year. Other limitations apply |
| | Children's dental check-up | Not covered | Not covered | This plan has no coverage for this service. |

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

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
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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 if meet criteria-no charge after [deductible](#), network only, prior approval required for coverage
- Chiropractic care-no charge after [deductible](#), to limit of 30 visits per calendar year, network only
- Infertility treatment to treat the underlying conditions that result in infertility only-covered as any other medical condition, network only
- Weight loss services other than surgery-covered as any other medical condition
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses like the deductible, copays or coinsurance, or benefits not otherwise covered. Contact your employer for details.

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 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 on how 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 and Language Access Services:

Physicians Health Plan (PHP) 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 800.832.9186 (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>.

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 تساعدته أسئلة بخصوص PHP، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 800.832.9186 - 517.364.8500 (TTY 711).

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 network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$8,550
- [Specialist cost share](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$5,550 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$50 |
| The total Peg would pay is | \$8,600 |

Managing Joe's Type 2 Diabetes

(a year of routine network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$8,550
- [Specialist cost share](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$5,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$5,020 |

Mia's Simple Fracture

(network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$8,550
- [Specialist cost share](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

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