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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf 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?	For network providers: $1,400 individual / $2,800 family For non-network providers: $4,000 individual / $8,000 family	Generally, you must pay all 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 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?	For network providers: Coinsurance Out-of-Pocket = $1,600 individual / $3,200 family Maximum Out-of-Pocket = $8,000 individual / $16,000 family For non-network providers: Maximum Out-of-Pocket = $15,000 individual / $30,000 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, 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	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

	a list of network providers.	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 specialist you choose without a referral.

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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	$25 copay/office visit; deductible does not apply 20% coinsurance after deductible for associated services	30% coinsurance after deductible	Convenience care facilities are covered under this benefit.
	Specialist visit	$50 copay/office visit; deductible does not apply 20% coinsurance after deductible for associated services	30% coinsurance after deductible	Allergy services (not including injections) are covered at 50% coinsurance after deductible and 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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	30% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	$150 copay/procedure after deductible	30% coinsurance after deductible	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	Tier 1 drugs (mostly Generic)	$20 copay/prescription (retail) $40 copay/prescription (mail order)	Only covered for emergent/urgent condition	Deductible does not apply to outpatient prescription drug copays or coinsurance amounts. Covers up to a 31-day supply (retail prescription); 32-90-day supply (mail order prescription). If you want a brand-name drug that has a generic drug that is chemically the same, you
	Tier 2 drugs (mostly Preferred brand-name)	$50 copay/prescription (retail) $100 copay/prescription (mail order)	Only covered for emergent/urgent condition	

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)	
	Tier 3 drugs (mostly Non-Preferred brand-name)	$80 copay/prescription (retail) $160 copay/prescription (mail order)	Only covered for emergent/urgent condition	pay your applicable cost share plus the difference between the brand-name and generic price. 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 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. Some drugs require prior approval for coverage. Call PHP for more information.
	Tier 4 Non-Preferred Specialty drugs	Not available (retail) 20% coinsurance up to maximum copay/prescription of $300 (mail-order)	Only covered for emergent/urgent condition	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	30% coinsurance after deductible	Female sterilization is covered at no member cost share when using network providers. Some surgeries are covered at 50% coinsurance after deductible from network providers only. Prior approval required for coverage of reconstructive procedures.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	Female sterilization is covered at no member cost share when using network providers. Some surgeries are covered at 50% coinsurance after deductible from network providers only. Prior approval required for coverage of reconstructive procedures
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	Same as network benefit	Prior approval required, and deductible and copay waived if admitted for an inpatient stay.
	Emergency medical transportation	20% coinsurance after deductible	Same as network benefit	None
	Urgent care	$60 copay/visit; deductible does not apply 20% coinsurance after	Same as network benefit	None

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)	
		deductible for associated services		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	30% coinsurance after deductible	Prior approval required for coverage. Some surgeries are covered at 50% coinsurance after deductible from network providers only. Transplants must be at Designated Facilities.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	Prior approval required for coverage. Some surgeries are covered at 50% coinsurance after deductible from network providers only.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply 20% coinsurance after deductible for ABA services for autism treatment	30% coinsurance after deductible ABA services not covered	Prior approval required for coverage of non-routine services including ABA services.
	Inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Prior approval required for coverage.
If you are pregnant	Office visits	Included in professional services below	Included in professional services below	Certain prenatal tests are covered with no member cost share when using network providers. Prior approval required for coverage if inpatient stay exceeds federally established minimum time frames. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound.).
	Childbirth/delivery professional services	20% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	30% coinsurance after deductible	Prior approval required for coverage.
	Rehabilitation services	$50 copay/visit after deductible	30% coinsurance after deductible	Calendar year network/non-network maximums: outpatient speech therapy – 30 visits; outpatient physical therapy and occupational therapy – 30 visits; spinal treatment – 30 visits; pulmonary and cardiac rehabilitation therapy – 30 visits.

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)	
				Prior approval required for coverage of outpatient speech therapy, physical therapy, and occupational therapy.
	Habilitation services	$50 copay/visit after deductible	30% coinsurance after deductible Autism treatment not covered	Calendar year network/non-network maximums: outpatient speech therapy – 30 visits; outpatient physical therapy and occupational therapy – 30 visits; spinal treatment – 30 visits. Covered services for treatment of autism are not included in above limits. Prior approval required for coverage of outpatient speech therapy, physical therapy, and occupational therapy.
	Skilled nursing care	20% coinsurance after deductible	30% coinsurance after deductible	Combined network/non-network limit for skilled nursing facility care and hospice facility care of 45 days per calendar year. Prior approval required for coverage.
	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	20% coinsurance after deductible	30% coinsurance after deductible	Combined network/non-network limit for hospice facility care and skilled nursing 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	20% coinsurance 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.

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

* For more information about limitations and exceptions, see the plan or policy document at www.phpmichigan.com.

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-50% coinsurance after deductible, network only, prior approval required for coverage	• Chiropractic care-network: $30 copay/visit after deductible, non-network: 30% coinsurance after deductible; to limit of 30 visits per calendar year combined with D.O. manipulation	• Infertility treatment to treat the conditions that result in infertility only-network and non-network: covered as any other medical condition • Weight management services –covered depending on where service is received, network only

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, contact your state insurance department, 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.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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.

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.

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 800.832.9186 - 517.364.8500.

Chinese 如果您，或是您正在協助的對象，有關於[插入 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。洽詢一位翻譯員，請撥電話 [在此插入數字517.364.8500 - 800.832.9186.

* For more information about limitations and exceptions, see the plan or policy document at www.phpmichigan.com.

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 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.

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 までお電話ください。

Korean 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 PHP 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용
부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는517.364.8500 - 800.832.9186로 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

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.

Syriac

ܐܝܟ ܐܢܬ ܐܘ ܡܢ ܐܢܬ ܥܒܕ ܠܗ ܥܕܪ ܒ PHP ܥܠ ܫܐܠܬ̈ܐ ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܢܣܒ ܥܕܪܐ ܒܠܫܢܟ ܒܠܚܘܕ ܕܠܐ ܡܫܠܡ ܐܢ ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܬܟܠܡ ܥܡ ܡܬܪܓܡܢܐ ܬܨܠ ܠ
.517.364.8500 - 800.832.9186

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.

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.

Bengali যদি আপনি, 517.364.8500 - 800.832.9186 আপনি অথবা কাউকে সহায়তা করছেন, সম্পর্কে প্রশ্ন আছে PHP, আপনার অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন 517.364.8500 - 800.832.9186.

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.

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.

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

* For more information about limitations and exceptions, see the plan or policy document 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)

The plan's overall deductible	$1,400
Specialist	$50
Hospital (facility)	20%
Other	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$130
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,190**

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

The plan's overall deductible	$1,400
Specialist	$50
Hospital (facility)	20%
Other	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$107
Copayments	$2,610
Coinsurance	$27
What isn't covered	
Limits or exclusions	$49
The total Joe would pay is	**$2,793**

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

The plan's overall deductible	$1,400
Specialist	$50
Hospital (facility)	20%
Other	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,128
Copayments	$350
Coinsurance	$294
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,773**

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