This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at our Member Reference Desk or by calling 1-800-832-9186 or 517-364-8500 locally.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers: **$500** individual / **$1,000** family Does not apply to copays and other benefits as noted. For non-network providers: **$1,000** individual / **$2,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For network providers: **$3,200** individual / **$6,400** family For non-network providers: **$4,000** individual / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.phpmichigan.com or call 1-800-832-9186 or 517-364-	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this

	8500 locally.	plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	
	Specialist visit	$20 copay/visit	30% coinsurance	
	Other practitioner office visit	$20 copay/visit for chiropractic services	Not covered for chiropractic services	Chiropractic services are limited to 18 visits per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition	Tier 1 drugs (mostly generic)	$5 copay/prescription (up to 31-day supply) $10 copay/prescription (up	Only covered for emergent/urgent condition.	Covers up to a 31-day supply (retail prescription); 32-90 day supply (mail order or retail prescription).

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at https://www.caremark.com/wps/portal		to 90-day supply)		ACA mandated preventive drugs such as select contraceptive and tobacco cessation medications are covered with no member cost share. Preferred Tobacco Cessation Products are not available in 32 to 90-day supplies. Some drugs require prior approval. Call PHP for more information.
	Tier 2 drugs (mostly Preferred brand name)	$30 copay/prescription (up to 31-day supply) $60 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition.	
	Tier 3 drugs (mostly non-Preferred brand name)	$60 copay/prescription (up to 31-day supply) $120 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition.	
	Specialty drugs	40% coinsurance for infertility medications. For other specialty drugs, tier level depends on the drug. Please see the drug formulary list available online or contact Customer Service.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Female sterilization is covered at no member cost share when using network providers. Prior approval required for reconstructive procedures.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Female sterilization is covered at no member cost share when using network providers. Prior approval required for reconstructive procedures.
If you need immediate medical attention	Emergency room services	$100 copay/visit	Same as network benefit	Prior approval required and copay waived if admitted for an inpatient stay.
	Emergency medical transportation	20% coinsurance [$ copay/occurrence]	Same as network benefit	Prior approval required prior to non-emergency transport.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Urgent care	$50 copay/visit	Same as network benefit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Prior approval required. Transplants must be at Designated Facilities.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit for therapy visits and testing, and ABA services; no charge for other services and supplies	30% coinsurance ABA services not covered	Prior approval required for non-routine services, including ABA services.
	Mental/Behavioral health inpatient services	20% coinsurance	30% coinsurance	Prior approval required.
	Substance use disorder outpatient services	$20 copay/visit for therapy visits and testing, no charge for other services and supplies	30% coinsurance	Prior approval required for non-routine services.
	Substance use disorder inpatient services	20% coinsurance	30% coinsurance	Prior approval required.
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	Certain prenatal tests are covered with no member cost share when using network providers.
	Delivery and all inpatient services	Delivery: no charge, Inpatient services: 20% coinsurance	30% coinsurance	Prior approval required if inpatient stay exceeds federally established minimum time frames.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Combined network/non-network limit of 60 visits per calendar year. Prior approval required.
	Rehabilitation services	$20 copay/visit	30% coinsurance	Combined network/non-network limits: PT/OT/ST/pulmonary = 60 visits per calendar year; cardiac rehab = 36 visits per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
				Prior approval required for all outpatient rehabilitation therapy.
	Habilitation services for treatment of Autism Spectrum Disorders for children from birth through age 18	$20 copay/visit	Not covered	Prior approval required.
	Skilled nursing care	20% coinsurance	30% coinsurance	Combined network/non-network limit of 100 days per calendar year. Prior approval required.
	Durable medical equipment	20% coinsurance	30% coinsurance	Prior approval required on certain items of DME. Call PHP for current information.
	Hospice service	No charge	30% coinsurance	Prior approval required.
If your child needs dental or eye care	Eye exam	No charge	Not covered	This is a preventive service. Limited to 1 routine exam per calendar year.
	Glasses	Not covered	Not covered	This plan has no coverage for this service.
	Dental check-up	Not covered	Not covered	This plan has no coverage for this service.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Experimental or investigational procedures and services
- Hearing aids
- Infertility treatment to conceive pregnancy
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult) – other than eye exam (see below)
- Routine foot care
- Services that are not medically necessary as determined by PHP medical policy and national guidelines

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery if meet criteria-10% coinsurance up to $1,000 copay, deductible waived, network only, prior approval required
- Chiropractic care-$20 copay/visit, deductible waived, to limit of 18 visits per calendar year, network only
- Elective abortion as defined by the State of Michigan
- Infertility treatment to treat the conditions that result in infertility only-50% coinsurance, to limits of: 5 office visits and 3 diagnostic or surgical procedures, per calendar year, network only
- Routine eye care (adult) – routine eye exam only: no charge, to limit of 1 exam per calendar year, network only
- Weight loss programs if meet criteria-$25 copay/visit for most services, deductible waived, network only

Your Rights to Continue Coverage:

If you have coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For information on your rights to continue coverage, contact the plan at 1-800-832-9186 or 517-364-8500 locally. You may also 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-800-832-9186 or 517-364-8500 locally.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,086
- **Patient pays** $1,454

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$10
Coinsurance	$794
Limits or exclusions	$150
Total	**$1,454**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,424
- **Patient pays** $976

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$879
Coinsurance	$0
Limits or exclusions	$97
Total	**$976**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Meaningful Access

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. This notice is also available in alternative formats upon request and at no cost to persons with disabilities.

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

إذا 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.

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.

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

[illegible] PHP [illegible]
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.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 আপদি, 517.364.8500 - 800.832.9186 আপদি অিয কাউকক সহায়তা করকেি, স◆ককে ◆◆ আকে PHP, আপিার অদিকার আকে দবিা খরকে আপিার দিজ◆ ভাষাকত সাহাযয পাবার এবং তথয জাি◌বার। অিুবাি◌ককর সাকথ কথা বলার জিয, কল করি◌ 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.