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 1.800.203.9519 or 517.364.8456 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 1.800.203.9519 or 517.364.8456 locally to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $500 individual / $1,000 family For out-of-network providers: $2,000 individual / $4,000 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, services subject to copayments, 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 in-network providers: $3,000 individual / $6,000 family For out-of-network providers: $6,000 individual / $12,000 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?	Caregiver contributions, balance-billing charges, certain out-of-network or non-EHB services (see SPD for full details), 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. For a list of network providers click SPN Provider Directory or call 1.877.275.0076 or 364.8432 locally.	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

	The SPN Network includes select Spectrum Health System providers.	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
		In-Network Provider (You will pay the least)	Out-of-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	SCN Provider: $15 copay/visit; deductible does not apply SPN Provider: $20 copay/visit; deductible does not apply	40% coinsurance after deductible	Convenience care facilities such as FastCare are covered under this benefit.
	Specialist visit	SCN Provider: $25 copay/visit; deductible does not apply SPN Provider: $40 copay/visit; deductible does not apply	40% coinsurance after deductible	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)	10% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	$75 copay/procedure after deductible	40% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Tier 1 drugs (mostly Generic)	$10 copay/prescription (up to 34-day supply) $20 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition	Deductible does not apply to copays for outpatient prescription drugs.] Covers up to a 34-day supply (retail prescription); 35-90-day supply (mail order or retail prescription). ACA mandated preventive drugs such as select contraceptive and tobacco cessation
	Tier 2 drugs (mostly Preferred brand-name)	$40 copay/prescription (up to 34-day supply)	Only covered for emergent/urgent condition	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
https://www.caremark.com/wps/portal		$80 copay/prescription (up to 90-day supply)		medications are covered with no member cost share. Preferred Tobacco Cessation Products are only available from retail network pharmacies in up to 34-day supply. All Specialty Drugs regardless of tier placement are only available in up to 34-day supply. If a brand-name drug has a generic drug that is chemically the same, you pay your applicable copay plus the difference between the brand-name and generic price. Some drugs require prior approval for coverage. Call PHP Service Company for more information.
	Tier 3 drugs (mostly Non-Preferred brand-name)	$80 copay/prescription (up to 34-day supply) $160 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition	
	Tier 4 Non-Preferred Specialty drugs	$150 copay/prescription (up to 34-day supply) Not available (up to 90-day supply)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	40% coinsurance after deductible	Female sterilization is covered at no member cost share when using in-network providers. Pregnancy termination is covered with $100 copay, limited to 1 per lifetime. Prior approval required for coverage of reconstructive procedures.
	Physician/surgeon fees	SCN Provider: No charge SPN Provider: No charge after deductible	40% coinsurance after deductible	Female sterilization is covered at no member cost share when using in-network providers. Pregnancy termination covered with $100 copay, limited to 1 per lifetime. Prior approval required for coverage of reconstructive procedures.
If you need immediate medical attention	Emergency room care	Sparrow Carson, Clinton & Ionia Hospitals: $150 copay/visit; deductible does not apply. All other in-network hospitals: $250 copay/visit; deductible does not apply.	$250 copay/visit; deductible does not apply	Prior approval required, and copay waived if admitted for an inpatient stay.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	10% coinsurance after deductible	Same as network benefit	None
	Urgent care	Sparrow Facilities: $25 copay/visit; deductible does not apply. Non-Sparrow Facilities: $50 copay/visit; deductible does not apply.	$50 copay/visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	40% coinsurance after deductible	Prior approval required for coverage. Transplants must be at Designated Facilities.
	Physician/surgeon fees	SCN Provider: No charge SPN Provider: No charge after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy visits & testing, ABA services SCN Provider: $15 copay/visit; deductible does not apply SPN Provider: $20 copay/visit; deductible does not apply Other services and supplies No charge	40% coinsurance after deductible ABA services not covered	Prior approval required for coverage of non-routine services, including ABA services.
	Inpatient services	No charge after deductible	40% 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	SCN Provider: No charge SPN Provider: No charge after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	No charge after deductible	40% coinsurance after deductible	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	50% coinsurance after deductible	Combined in-network/out-of-network limit of 60 visits per calendar year. Prior approval required for coverage.
	Rehabilitation services	10% coinsurance after deductible	40% coinsurance after deductible	Combined in-network/out-of-network limits: PT/OT/ST/pulmonary = 36 visits per calendar year; cardiac rehab = 36 visits per calendar year. Prior approval required for coverage of outpatient physical, occupational and speech therapy.
	Habilitation services for treatment of Autism Spectrum Disorders for children from birth through age 18	10% coinsurance after deductible	Not covered	Prior approval required for coverage.
	Skilled nursing care	No charge after deductible	50% coinsurance after deductible	Combined in-network/out-of-network limit of 100 days per calendar year. Prior approval required for coverage.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Prior approval required for coverage of certain items of DME. Call PHP Service Company for current information.
	Hospice services	10% coinsurance after deductible	40% coinsurance after deductible	Prior approval required for coverage.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	This plan has no coverage for this service.
	Children's glasses	Not covered	Not covered	This plan has no coverage for this service.
	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
- Habilitation services except to treat Autism Spectrum Disorders
- Hearing aids and services
- Infertility treatment 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-10% coinsurance up to $1,000 copay, deductible does not apply, in-network only, prior approval required for coverage • Chiropractic care-out-of-network only: 50% coinsurance after deductible, to limit of 12 visits per calendar year	• Infertility treatment to treat the underlying conditions that result in infertility only-covered as any other medical condition	• Weight loss services other than surgery-40% coinsurance after deductible for most services, in-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 Service Company 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 [在此插入数字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.

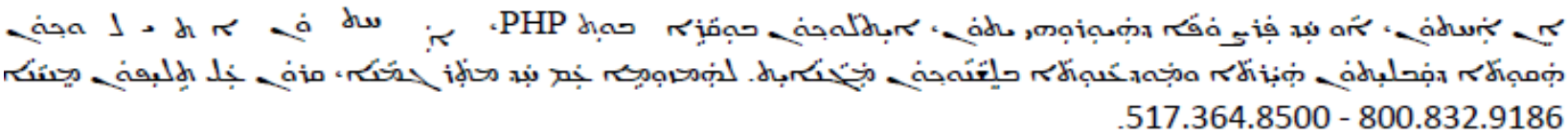
Japanese ご本人様、またはお客様の身の回りの方でも、PHP についてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。 通訳とお話される場合、517.364.8500 - 800.832.9186 までお電話ください。

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



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 দাবী করতে 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	$500
Specialist	$20
Hospital (facility)	0%
Other	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$70
Coinsurance	$105
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$735**

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

The plan's overall deductible	$500
Specialist	$20
Hospital (facility)	0%
Other	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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$1,720
Coinsurance	$13
What isn't covered	
Limits or exclusions	$49
The total Joe would pay is	**$1,903**

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

The plan's overall deductible	$500
Specialist	$20
Hospital (facility)	0%
Other	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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$107
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$667**

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