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.healthcare.gov/sbc-glossary 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: $250 individual / $500 family For out-of-network providers: $1,000 individual / $2,000 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, 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: $6,600 individual / $13,200 family For out-of-network providers: $6,600 individual / $13,200 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 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 billing). Be aware, your network provider might use an out-of-network provider for some

Important Questions	Answers	Why This Matters:
		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 **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
		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: No charge SPN Provider: $15 copay/visit, deductible does not apply	$50 copay/visit after deductible	Out-of-network copay is not subject to the out-of-network deductible if due to an emergent/urgent condition. Convenience care facilities such as FastCare are covered under this benefit.
	Specialist visit	SCN Provider: $15 copay/visit, deductible does not apply SPN Provider: $30 copay/visit, deductible does not apply	$100 copay/visit after deductible	Out-of-network copay is not subject to the out-of-network deductible if due to an emergent/urgent condition. Reversal of surgical sterilization is covered with 25% coinsurance in-network 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)	No charge after deductible	30% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug**	Tier 1 drugs (mostly Generic)	Up to 34-Day Supply Sparrow Pharmacies: $7.50 copay Caremark Pharmacies: $15 copay Up to 90-Day Supply Sparrow Pharmacies: $15 copay Caremark Pharmacies: $30 copay	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

* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
coverage is available at https://www.caremark.com/wps/portal.	Tier 2 drugs (mostly Preferred brand-name)	Up to 34-Day Supply Sparrow Pharmacies: $30 copay Caremark Pharmacies: $50 copay Up to 90-Day Supply Sparrow Pharmacies: $60 copay Caremark Pharmacies: $100 copay	Only covered for emergent/urgent condition	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 34-day supply. All Specialty Drugs regardless of tier placement are only available from CVS mail-order specialty pharmacy in up to a 34-day supply. If Caregiver requests a brand name drug without DAW (Dispense as Written) from prescribing physician and a generic equivalent is available, the generic drug is dispensed and Caregiver pays applicable generic drug copay. If provider prescribes a brand name drug with DAW, brand name drug is dispensed and Caregiver pays applicable non-preferred brand name drug copay. If Caregiver requests a brand name drug but the prescription from the prescribing provider does not state DAW, brand name drug is dispensed and the Caregiver pays 100% of the contracted rate. Some drugs require prior approval for coverage. Call PHP Service Company for more information.
	Tier 3 drugs (mostly Non-Preferred brand-name)	Up to 34-Day Supply Sparrow Pharmacies: $75 copay Caremark Pharmacies: $100 copay Up to 90-Day Supply Sparrow Pharmacies: $150 copay Caremark Pharmacies: $200 copay	Only covered for emergent/urgent condition	
	Specialty drugs	Tier level depends on the drug. Please see the drug formulary list available on the Sparrow Intranet HR Home Page	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% 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. Reversal of surgical sterilization is covered with 25% coinsurance after deductible in-network only.

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)	
				Prior approval required for coverage of reconstructive procedures.
	Physician/surgeon fees	SCN Provider: No charge SPN Provider: No charge after deductible	30% coinsurance after deductible	Prior approval required for coverage of reconstructive procedures.
If you need immediate medical attention	Emergency department care	Sparrow Carson, Clinton, Eaton & Ionia Hospitals: $100 copay/visit; deductible does not apply. All other in-network hospitals: $200 copay/visit; deductible does not apply.	$200 copay/visit, deductible does not apply	Prior approval is required for coverage and the copay is waived if admitted directly from the Emergency Department for an inpatient stay.
	Emergency medical transportation	No charge after deductible	30% coinsurance after deductible Same as in-network benefit if accident/ emergent illness/ transfer by Plan	
	Urgent care	Sparrow Facilities: $25 copay/visit; deductible does not apply. Non-Sparrow Facilities: $50 copay/visit; deductible does not apply.	$100 copay/visit; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% coinsurance after deductible	Prior approval required for coverage of inpatient stays. Transplants must be at Designated Facilities.
	Physician/surgeon fees	SCN Provider: No charge SPN Provider: No charge after deductible	30% coinsurance after deductible	Reversal of surgical sterilization is covered with 25% coinsurance after deductible in-network only.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy visits & testing, ABA services SCN Provider: No charge SPN Provider: $15 copay/visit; deductible does not apply	30% coinsurance after deductible ABA services not covered	Prior approval required for coverage of non-routine services, including ABA services and inpatient stays.

* 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Other services and supplies No charge		
	Inpatient services	No charge after deductible	30% coinsurance after deductible	
If you are pregnant	Office visits	Included in professional services below	Included in professional services below	Cost sharing does not apply for preventive services. 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	SCN Provider: No charge SPN Provider: No charge after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	No charge after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No charge 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	$15 copay/visit, deductible does not apply	30% 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. 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 for treatment of Autism Spectrum Disorders for children from birth through age 18	$15 copay/visit, deductible does not apply	Not covered	
	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	No charge 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	No charge after deductible	30% coinsurance after deductible	Prior approval required for coverage.

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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 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	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 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) – other than eye exam (see below)
- 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-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
- Routine eye care (adult) – routine eye exam only: no charge, to limit of 1 exam per calendar year, in-network only
- Weight loss services other than surgery-40% coinsurance after deductible for most services, in-network only
- 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, 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 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

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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? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800.832.9186 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800.832.9186 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 800.832.9186 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電800.832.9186 (TTY: 711)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800.832.9186 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800.832.9186 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800.832.9186 (TTY: 711) まで、お電話にてご連絡ください

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.832.9186 (TTY: 711) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800.832.9186 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800.832.9186 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa -800.832.9186 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800.832.9186 (TTY: 711).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800.832.9186 (TTY: 711)।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800.832.9186 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800.832.9186 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Syriac:

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܡܣܘܚܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܫܟܚܬ ܕܩܒܠܬ ܚܠܦܘܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ
ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-800-649-3777 (TTY: 711)

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 certificate of coverage 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 network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$250**
- **Specialist cost sharing** **$15**
- **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:	
Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$310**

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

- **The plan's overall deductible** **$250**
- **Specialist cost sharing** **$15**
- **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:	
Cost Sharing	
Deductibles	$250
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$930**

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

- **The plan's overall deductible** **$250**
- **Specialist cost sharing** **$15**
- **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:	
Cost Sharing	
Deductibles	$250
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Mia would pay is	**$870**

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