



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 www.phpmm.org 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: \$0 individual / \$0 family For non-network providers: \$200 individual / \$400 family	You must pay all the costs up to the <u>non-network deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>non-network deductible</u> 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 <u>non-network deductible</u> .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For network providers: \$3,000 individual / \$6,000 family For non-network providers: \$3,000 individual / \$3,000 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>?	Deductibles, copays, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of <u>network providers</u> , see www.phpmm.org or call 1-800-832-9186 or 517-364-8500 locally.	If you use a network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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Physicians Health Plan: HMO Plan (Active hired prior to 4/1/10) Coverage Period: 10/13/2013 – 10/12/2014
Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Plan: DPL06902, RX080355**

Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 copay/visit	20% coinsurance	
	Specialist visit	\$10 copay/visit	20% coinsurance	
	Other practitioner office visit	\$10 copay/visit for chiropractic services	Not covered	Chiropractic services are limited to 20 visits per calendar year.
	Preventive care/screening/immunization	0% coinsurance	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	Your provider is required to notify HealthHelp prior to services.
If you need drugs to treat your illness or condition	Tier 1 drugs (mostly generic)	\$5 copay/prescription (retail) \$10 copay/prescription (mail order)	Only covered for emergent/urgent condition.	Covers up to a 31-day supply (retail prescription); 32-90 day supply (mail order prescription). Select contraceptive and tobacco cessation medications covered with no
More information				

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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
about <u>prescription drug coverage</u> is available at www.express-scripts.com .	Tier 2 drugs (mostly Preferred brand name)	\$10 copay/ prescription (retail) \$20 copay/ prescription (mail order)	Only covered for emergent/urgent condition.	member cost share. Preferred Tobacco Cessation Products are not available from mail-order service. Some drugs require authorization. Call PHP for more information.
	Tier 3 drugs (mostly non-Preferred brand name)	Not covered	Not covered	
	Specialty drugs	0% coinsurance for growth hormone therapy 40% coinsurance for infertility medications 50% for weight loss medications	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	Female sterilization is covered at no member cost share when using network providers. Authorization required for reconstructive procedures. Your provider is required to notify HealthHelp prior to certain cardiac and oncology procedures.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Female sterilization is covered at no member cost share when using network providers. Authorization required for reconstructive procedures. Your provider is required to notify HealthHelp prior to certain cardiac and oncology procedures.

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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 need immediate medical attention	Emergency room services	\$50 copay/visit	Same as network benefit	Authorization required and copay waived if admitted for an inpatient stay.
	Emergency medical transportation	0% coinsurance	Same as network benefit	Authorization required prior to non-emergency transport.
	Urgent care	\$10 copay/visit	Same as network benefit	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Authorization required. Transplants must be at Designated Facilities.
	Physician/surgeon fee	0% coinsurance	20% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance for first 20 therapy visits or testing in a calendar year, then \$10 copay/visit; 0% coinsurance for other services and supplies	20% coinsurance	Authorization required for non-routine services. Call UBH at 800-608-2667.
	Mental/Behavioral health inpatient services	0% coinsurance	20% coinsurance	Authorization required. Call UBH at 800-608-2667.
	Substance use disorder outpatient services	0% coinsurance	20% coinsurance	Authorization required for non-routine services. Call UBH at 800-608-2667.
	Substance use disorder inpatient services	0% coinsurance	20% coinsurance	Authorization required. Call UBH at 800-608-2667.
If you are pregnant	Prenatal and postnatal care	0% coinsurance	20% coinsurance	Certain prenatal tests are covered with no member cost share.
	Delivery and all inpatient services	0% coinsurance	20% coinsurance	Authorization required if inpatient stay exceeds minimum time frames.
If you need help recovering or have	Home health care	0% coinsurance	20% coinsurance	Combined network/non-network limit of 60 visits per calendar year.

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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
other special health needs				Authorization required.
	Rehabilitation services	\$10 copay/visit	20% coinsurance	Combined network/non-network limits: PT/OT/ST/pulmonary = 60 visits per calendar year; cardiac rehab = 36 visits per calendar year. Authorization required for all outpatient rehabilitation therapy.
	Habilitation services for treatment of Autism Spectrum Disorders for children from birth through age 18	\$10 copay/visit	Not covered	Authorization required. Applied Behavioral Analysis (ABA) is limited per calendar year to \$50,000.
	Skilled nursing care	0% coinsurance	20% coinsurance	Non-network limit of 100 days per calendar year. Authorization required.
	Durable medical equipment	0% coinsurance	20% coinsurance	Shoe orthotics are covered. Authorization required if DME more than \$500 to rent or purchase.
	Hospice service	0% coinsurance	20% coinsurance	Authorization required.
If your child needs dental or eye care	Eye exam	0% coinsurance	Not covered	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.

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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.)

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|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (adult) • Experimental or investigational procedures and services | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (adult)-other than exam (see below) | <ul style="list-style-type: none"> • 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.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Bariatric surgery if meet criteria-10% coinsurance up to \$1,000 copay, network only • Chiropractic care - \$10 per visit, to limit of 20 visits per calendar year, network only | <ul style="list-style-type: none"> • Hearing aids and services: 0% coinsurance, to limit of either monaural to \$880 or binaural to \$1,600 in 36-month period, network only • Infertility treatment to treat the conditions that result in infertility only-0% coinsurance to limit of \$10,000 per calendar year, network only | <ul style="list-style-type: none"> • Routine eye care (adult) – routine eye exam only: 0% coinsurance, to limit of 1 exam per calendar year, network only • Weight loss programs if meet criteria - \$25 copay/visit, network only |
|---|--|--|

Your Rights to Continue Coverage:

If you lose coverage under the plan, the, 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 more 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.

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

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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 \$7,380**
- **Patient pays \$160**

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	\$0
Copays	\$10
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$160

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,764**
- **Patient pays \$636**

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	\$539
Coinsurance	\$0
Limits or exclusions	\$97
Total	\$636

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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.

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