

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

PriorityHealth : PriorityPOS Gold G15

Coverage Period: Beginning on or after 01/01/2024

Coverage for: Subscriber/Dependent | Plan Type: POS

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, visit us at PriorityHealth.com or call 1-800-446-5674. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-446-5674 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	For <u>participating providers</u> \$1,500 person / \$3,000 family For <u>non-participating providers</u> \$3,000 person / \$6,000 family The <u>deductible</u> for each benefit level is calculated separately. Amounts you pay toward the <u>deductible</u> do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, the preferred benefits <u>deductible</u> doesn't apply to <u>preventive care</u> , <u>home health care</u> , certain services subject to flat dollar <u>co-pays</u> , pediatric vision services or <u>prescription drugs</u> . Emergency room, ambulance, advanced imaging and certain rehabilitation services are some of the services subject to the <u>deductible</u> and a <u>co-pay</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>participating providers</u> \$8,200 person / \$16,400 family For <u>non-participating providers</u> \$16,400 person / \$32,800 family However, your plan also has a co-insurance maximum. For <u>participating providers</u> \$4,500 person / \$9,000 family For <u>non-participating providers</u> \$9,000 person / \$18,000 family The co-insurance maximum limits the total amount of <u>co-insurance</u> you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the <u>out-of-pocket limit</u> . The <u>out-of-pocket limit</u> and co-insurance maximum for each benefit level is calculated separately.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, additional cost you may pay if you choose to receive a brand name drug when an equivalent generic drug is available or a non-preferred drug when a preferred drug is available, services that exceed an annual day/visit limit, and any <u>co-pays</u> and <u>co-insurance</u> you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See PriorityHealth.com or call 1-800-446-5674 for a list of <u>participating providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do I need a referral to see a specialist?	No.	You can see the in-network <u>specialist</u> you choose without a <u>referral</u> .



All co-payment and co-insurance 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
		Participating Provider (You will pay the least)	Non-Participating 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	\$20 co-pay/ visit	40% co-insurance/ visit	Preferred benefit level deductible does not apply to certain services subject to flat dollar co-pays. Prescription drug co-pay may also apply when selected injectable drugs are provided.
	Specialist visit	\$50 co-pay/ visit	40% co-insurance/ visit	
	Other practitioner office visit	<ul style="list-style-type: none"> • \$85 co-pay/ visit for evaluation/ management services only at retail health clinics • 50% co-insurance/ visit for family planning/ infertility services • 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery 	<ul style="list-style-type: none"> • Evaluation/management services only at retail health clinics covered at the preferred benefit level • Family planning/ infertility services not covered • 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery 	
	Preventive care/screening/immunization	No charge	40% co-insurance/ visit	
If you have a test	Diagnostic test (x-ray, blood work)	<ul style="list-style-type: none"> • \$35 co-pay for labs (outpatient hospital or free-standing facility) • \$85 co-pay for radiology (outpatient hospital or free-standing facility) 	40% co-insurance	Prior authorization required for genetic testing. Appropriate office visit co-pay may apply for physician office services. Preferred benefit level deductible does not apply to flat dollar co-pays. 20% co-insurance when services provided as inpatient at a participating hospital facility.
	Imaging (CT/PET scans, MRIs)	\$250 co-pay/ service	40% co-insurance/ service	Prior authorization required. Preferred benefits co-pay waived if performed while confined in a hospital as an inpatient.

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

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi	Preferred generic drugs (Tier 1A)	\$5 co-pay/ retail prescription \$10 co-pay/ mail order prescription	Not covered	Costs shown in the "What You Will Pay" columns apply to drugs on the approved drug list when obtained from a Participating Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription) 50% co-insurance/ prescription for infertility drugs. Deductible does not apply.
	Other generic drugs (Tier 1B)	\$35 co-pay/ retail prescription \$70 co-pay/ mail order prescription	Not covered	
	Preferred brand drugs (Tier 2)	\$75 co-pay/ retail prescription \$150 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	\$85 co-pay/ retail prescription \$170 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs (Tier 4)	20% co-insurance/ retail prescription	Not covered	
	Non-Preferred specialty drugs (Tier 5)	20% co-insurance/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance/ visit	40% co-insurance/ visit	Including outpatient care, observation care and ambulatory surgery center care. Prior authorization may be required.
	Physician/surgeon fees	20% co-insurance/ visit	40% co-insurance/ visit	
	Certain Surgeries	50% co-insurance for each certain surgery	50% co-insurance for each certain surgery	Coverage includes physicians' fees and facility charges. Prior authorization is required for bariatric surgery, panniculectomy, rhinoplasty, and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
If you need immediate medical attention	Emergency room services	\$250 co-pay/ visit	Covered at the preferred benefit level; R&C limitations apply	Co-pay waived if you become confined in a Hospital as an inpatient.
	Emergency medical transportation	\$250 co-pay	Covered at the preferred benefit level; R&C limitations apply	-----none-----
	Urgent care	\$85 co-pay/ visit	40% co-insurance/ visit	Preferred benefit level deductible does not apply.

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

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance/ visit	40% co-insurance/ visit	Prior authorization is required, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Notification must be provided for all admissions following emergency room care.
	Physician/surgeon fee	20% co-insurance/ visit	40% co-insurance/ visit	
	Certain Surgeries	50% co-insurance for each certain surgery	50% co-insurance for each certain surgery	Coverage includes physicians' fees and facility charges. Prior authorization is required for bariatric surgery, panniculectomy, rhinoplasty, and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$20 co-pay/ visit	40% co-insurance/ visit	No charge for first three visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. Including medication management visits. Preferred benefit level deductible does not apply.
	Mental/Behavioral health inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including Residential Treatment and partial hospitalization. Except in an emergency, prior authorization required.
	Substance use disorder outpatient services	\$20 co-pay/ visit	40% co-insurance/ visit	Including medication management visits. Preferred benefit level deductible does not apply.
	Substance use disorder inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, prior authorization required.
If you are pregnant	Routine prenatal and postnatal care	No charge	40% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit.
	Delivery professional fees	20% co-insurance/ visit	40% co-insurance/ visit	-----none-----
	Delivery facility fees	20% co-insurance/ visit	40% co-insurance/ visit	-----none-----

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

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special needs	Home health care	No charge	40% co-insurance/ visit	Including hospice care services; excluding rehabilitation and habilitation services. Prior authorization required, except for hospice care. Preferred benefit level deductible does not apply.
	Rehabilitation services <i>not</i> for the treatment of Autism Spectrum Disorder	<ul style="list-style-type: none"> •\$50 co-pay/ visit for Physical, Occupational Speech Therapy; Cardiac & Pulmonary rehabilitation •\$40 co-pay/ visit for Osteopathic & Chiropractic manipulation 	50% co-insurance/ visit	Physical and occupational therapy limited to a combined 30 visits per contract year. Osteopathic and chiropractic manipulation limited to a combined 30 visits per contract year. Speech therapy limited to a combined 30 visits per contract year. Cardiac and pulmonary rehabilitation limited to a combined 30 visits per contract year. Preferred benefit level deductible does not apply to osteopathic and chiropractic manipulation.
	Habilitation services for treatment of Autism Spectrum Disorder <i>only</i>	<ul style="list-style-type: none"> •\$50 co-pay/ visit for Physical, Occupational and Speech Therapy •20% co-insurance/ visit for Applied Behavior Analysis (ABA) services 	50% co-insurance/ visit	Prior authorization required for Applied Behavior Analysis (ABA). Multiple charges may apply during one day of service. Preferred benefit level deductible does not apply to flat dollar co-pays.
	Habilitation services not for the treatment of Autism Spectrum Disorder	\$50 co-pay/ visit	50% co-insurance/ visit	Physical and occupational therapy limited to a combined 30 visits per contract year. Speech therapy limited to a combined 30 visits per contract year.
	Skilled nursing care	20% co-insurance/ visit	40% co-insurance/ visit	Services received in a skilled nursing care facility, subacute facility, or inpatient rehabilitation care are limited to a combined 45 days per contract year. Prior authorization required, except for hospice care.
	Durable medical equipment (DME)	50% co-insurance/ visit	50% co-insurance/ visit	Including rental, purchase or repair. Prior authorization required for equipment over \$1,000, all rentals and all shoe inserts. Preferred benefit level deductible does not apply to certain diabetes services and supplies.
	Prosthetics & orthotics	50% co-insurance/ visit	50% co-insurance/ visit	
	Hospice service	No charge	40% co-insurance/ visit	This benefit applies to hospice services provided in the home only. Any hospice services provided in a facility will be subject to the appropriate facility benefit. Preferred benefit level deductible does not apply.
If your child needs dental or eye care	Child eye exam	No charge	Not covered	One exam per year. Deductible does not apply.
	Child glasses	No charge	Not covered	Coverage limited to one select frame and one pair of eyeglass lenses or, in lieu of eyeglasses, contact lenses are covered up to a 6 month supply for 2-week disposable lenses, a 3 month supply of daily disposable lenses or one pair of conventional lenses. Deductible does not apply.
	Child dental check-up	Not covered	Not covered	Not covered

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Routine eye care (Adult & Child)
- Weight loss programs

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: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov; the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Priority Health at 1-800-446-5674 or www.priorityhealth.com; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or difs-HICAP@michigan.gov.

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 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-446-5674.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-446-5674.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-446-5674.

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

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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, co-payments, and co-insurance) and excluded services under this 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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Co-payments	\$600
Co-insurance	\$1,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	50%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Co-payments	\$1,500
Co-insurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,320

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	50%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Co-payments	\$700
Co-insurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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