PriorityHealth : PriorityPPO 100 Platinum 250

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

Coverage Period: Beginning on or after 01/01/2014
Coverage for: Subscriber/Dependent | Plan Type: PPO

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 **PriorityHealth.com** or by calling **1-888-389-6645**.

Important Questions	Answers	Why this Matters
What is the overall **deductible**?	For network providers **$250** person / **$500** family For non-network providers **$500** person / **$1,000** family The network benefits deductible doesn't apply to preventive care, pediatric vision services, prescription drugs, or certain services subject to flat dollar co-pays. Emergency room, ambulance and advanced imaging services are subject to the deductible and a co-pay. The deductible for each benefit level is calculated separately.	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 **$1,250** person / **$2,500** family. For non-network providers **$2,500** person / **$5,000** family. The out of pocket limits for each benefit level are calculated separately.	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, health care this plan doesn't cover, services that exceed an annual day/visit limit, and any co-pays, and coinsurance you pay for any non-essential health benefits. See plan documents for additional services that may not be included in the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a **network** of **providers**?	Yes. See **PriorityHealth.com** **or call 1-888-389-6645** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this 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 6. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.
- You may be able to pay your **deductible** and **Co-insurance** using money from a Health Reimbursement Account (HRA) or Flexible Spending Accounts (FSA).

Common Medical Events	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay/ visit	30% co-insurance/ visit	In-network benefits coverage includes services provided face-to-face, telephonically, or through secure electronic portal. Out-of-network benefits coverage includes face-to-face visits only. Prescription drug co-pay may also apply when selected injectable drugs are provided. See the Schedule of Benefits for a complete list of certain surgeries and treatments. Prior approval may be required. Dietician services include visits *not* listed in Priority Health's Preventive Health Care Guidelines. These services are limited to 6 visits per contract year. Prior approval is required for certain treatments of Autism Spectrum Disorder. See Habilitation Services below for additional information.
	Specialist visit	$25 co-pay/ visit	30% co-insurance/ visit	
	Other practitioner office visit	•$25 co-pay/ visit for dietician services •No charge for allergy testing, serum & injections •No charge for family planning/infertility services •50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery •Certain surgeries covered at no charge.	•Dietician services not covered •30% co-insurance for allergy testing, serum & injections •30% co-insurance/ visit for family planning/infertility services •50% co-insurance/ visit for Temporomandibular Joint Function (TMJ) treatment and Orthognatic surgery •30% co-insurance for each certain surgery.	
	Preventive care/screening/immunization	No charge	30% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% co-insurance	Appropriate office visit co-pay (PCP or specialist) may apply for physician office services.
	Imaging (CT/PET scans, MRIs)	$150 co-pay	30% co-insurance	Prior Approval required for certain radiology examinations. In-network benefits co-pay waived if performed while confined in a hospital as an inpatient.

Common Medical Events	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.priorityhealth.com/prog/pharmacy/pharmacy.cgi	Generic drugs	$10 co-pay/ retail prescription $20 co-pay/ mail order prescription	Not covered	Costs shown in the "Your Cost" columns apply to drugs on the approved drug list when obtained from a Network Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90 day supply (mail order prescription) Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable Copayments at a retail network pharmacy. 50% co-insurance/ prescription for infertility drugs. Deductible does not apply.
	Preferred brand drugs	$40 co-pay/ retail prescription $80 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs	$80 co-pay/ retail prescription $160 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs	20% co-insurance/ retail prescription	Not covered	The maximum co-pay for preferred specialty drugs is $100 per fill. The maximum co-pay for non-preferred specialty drugs is $200 per fill. Deductible does not apply.
	Non-Preferred specialty drugs	20% co-insurance/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% co-insurance/ visit	Includes network physician/surgeon fees and network facility fees for outpatient vasectomy services only when performed in connection with other covered outpatient surgery. Physician fees for vasectomy services performed in a network physician's office are covered with no charge. Deductible does not apply. Physician/surgeon fees and facility fees for outpatient tubal ligation services are covered with no charge when performed at a network facility by a network provider. Deductible does not apply. Tubal ligation services provided at non-network facilities and/or by non-network providers are covered at the non-network benefits level. See the Schedule of Benefits for a complete list of certain surgeries and treatments. Prior approval is required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.
	Physician/surgeon fees	No charge	30% co-insurance/ visit	
If you need immediate medical attention	Emergency room services	$150 co-pay/ visit	Covered at the network benefit level	Co-pay waived if you become confined in a Hospital as an inpatient.
	Emergency medical transportation	$150 co-pay	Covered at the network benefit level	-----------none-----------
	Urgent care	$75 co-pay/ visit	30% co-insurance/ visit	Co-pay applies to all urgent care visits.

Common Medical Events	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% co-insurance/ visit	Prior Approval is required at least 5 working days in advance, 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. Includes network physician/surgeon fees and network facility fees for inpatient vasectomy services only when performed in connection with other covered inpatient surgery. Physician/surgeon fees for inpatient tubal ligation services are covered with no charge when performed by a network provider. Deductible does not apply. Facility fees for inpatient tubal ligation are subject to deductible and co-insurance and covered only in connection with other covered inpatient surgery when performed at a network or non-network facility. Tubal ligation services provided at non-network facilities and/or by non-network providers are covered at the non-network benefits level. See the Schedule of Benefits for a complete list of certain surgeries and treatments. Prior approval is required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.
	Physician/surgeon fee	No charge	30% co-insurance/ visit	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 co-pay/ visit	30% co-insurance/ visit	Including medication management visits.
	Mental/Behavioral health inpatient services	No charge	30% co-insurance/ visit	Including partial hospitalization. Except in an emergency, prior approval required.
	Substance use disorder outpatient services	$10 co-pay/ visit	30% co-insurance/ visit	Including medication management visits.
	Substance use disorder inpatient services	No charge	30% co-insurance/ visit	Including subacute and partial hospitalization. Except in an emergency, prior approval required.
If you are pregnant	Routine prenatal and postnatal care	No charge	30% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Attendance at an approved maternity education program is covered with no charge. Deductible does not apply. Appropriate office visit co-pay (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.
	Delivery and all inpatient services	No charge	30% co-insurance/ visit	Deductible applies to facility charges for delivery.

Common Medical Events	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you need help recovering or have other special health needs	Home health care	No charge	30% co-insurance/ visit	Including Hospice Care services; excluding rehabilitation services and habilitation services. Prior Approval required after first 30 days of health care services except for Hospice Care services in the home. Rehabilitation services and habilitation services provided in the home are subject to the limitations of the Rehabilitation Services and Habilitation Services benefits described below. Deductible does not apply.
	Rehabilitation services These services are *not* for the treatment of Autism Spectrum Disorder	$10 co-pay/ visit	50% co-insurance/ visit	Physical and occupational therapy (Including osteopathic and chiropractic manipulation) limited to a combined 30 visits/ contract year. Speech therapy limited to a combined 30 visits/ contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits/ contract year.
	Habilitation services for treatment of Autism Spectrum Disorder ***only***	$10 co-pay/ visit	50% co-insurance/ visit	Prior approval required for Applied Behavioral Analysis. Physical, occupational, and speech therapy and Applied Behavioral Analysis (ABA) are covered up to a combined 135 days per contract year for treatment of Autism Spectrum Disorder only and are available for children and adolescents through the age of 18 only.
	Habilitation services *not* for the treatment of Autism Spectrum Disorder	$10 co-pay/ visit	50% co-insurance/ visit	Physical and occupational therapy limited to a combined 30 visits/ contract year. Speech therapy limited to a combined 30 visits/ contract year.
	Skilled nursing care	No charge	30% co-insurance/ visit	Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 45 days per contract year. Prior approval required.
	Durable medical equipment (DME)	50% co-insurance/ visit	50% co-insurance/ visit	Including rental, purchase or repair. Prior Approval required for equipment over $1,000.
	Prosthetics & orthotics	50% co-insurance/ visit	50% co-insurance/ visit	
	Hospice services	No charge	30% 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. Deductible does not apply.
If your child needs dental or eye care	Eye exam	No charge	Not covered	One exam per contract year. Deductible does not apply.
	Glasses	No Charge	Not covered	Coverage limited to one frame and one pair of eyeglass lenses or, in lieu of eyeglasses only, contact lenses are covered up to a six month supply for 2-week disposable lenses, a three month supply of daily disposable lenses or one pair of conventional lenses. Formulary applies. Deductible does *not* apply.
	Dental check-up	Not covered	Not covered	Not covered

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 & Child)	• Hearing aids • Long-term care • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

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 • Chiropractic care • Emergency services provided outside the U.S.	• Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility	• Non-emergency care when traveling outside the U.S. • Routine eye care (Adult & Child) • Weight loss programs

Your Rights to Continue Coverage:

If you lose 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 more information on your rights to continue coverage, contact the plan at 1-888-389-6645. 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:

- Priority Health at 1-888-389-6645 or visit www.priorityhealth.com;
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or
- The Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or ofir-HICAP@michigan.gov

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 does provide minimum essential coverage.

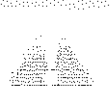
Does this Coverage Meet the Minimum Value Standard?

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 benefit 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.

NOTE: These examples demonstrate possible costs under Subscriber only coverage. If you have Subscriber/Dependent coverage, your costs may be different.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,120
- **Patient pays** $420

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	$250
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$150
Total	**$420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,070
- **Patient pays** $1,330

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	$250
Co-pays	$480
Co-insurance	$520
Limits or exclusions	$80
Total	**$1,330**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-389-6645.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-389-6645.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-389-6645.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-389-6645.

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.