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

**Coverage Period: Beginning on or after 04/01/2017**

**PriorityHealth : PriorityPOS 250 90%**

**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 participating providers $250 person / $500 family<br>For non-participating providers $500 person / $1,000 family<br>The deductible for each benefit level is calculated separately. Amounts you pay toward the deductible do not count toward any co-insurance maximums. | 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, the preferred benefits deductible doesn't apply to preventive care, home health care, certain services subject to flat dollar co-pays, pediatric vision services or prescription drugs. Emergency room, ambulance and advanced imaging services are subject to the deductible and a co-pay. | 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?** | Yes. For participating providers $5,000 person / $10,000 family<br>For non-participating providers $10,000 person / $20,000 family<br>However, your plan also has a co-insurance maximum.<br>For participating providers $1,500 person / $3,000 family<br>For non-participating providers $3,000 person / $6,000 family<br>The co-insurance maximum limits the total amount of co-insurance you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the out-of-pocket limit. The out-of-pocket limit and co-insurance maximum for each benefit level is calculated separately. | 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?** | Premiums, balance-billed charges, health care this plan doesn't cover, additional cost you may pay if you choose to receive a brand name drug when an equivalent generic drug is available, services that exceed an annual day/visit limit, and any co-pays and co-insurance you pay for any non-essential health benefit. | 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<br>or call 1-800-446-5674 for a list of participating providers. | 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 services (such as lab work). Check with your provider before you get services. |
| **Do I need a referral to see a specialist?** | No, you don't need a referral in order to receive the preferred benefit for services provided by a participating specialist.<br>Yes, you do need a referral in order to receive the preferred benefit for services provided by a non-participating specialist. | You can see the in-network specialist you choose without a referral.<br>This plan will pay some or all of the costs to see an out-of-network specialist for covered services but only if you have a referral before you see the specialist. |

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 | $10 co-pay/ visit | 30% co-insurance/ visit | Preferred benefit level deductible does not apply to certain services subject to flat dollar co-pays.<br>Prescription drug co-pay may also apply when selected injectable drugs are provided.<br>Retail health clinic services are covered at reasonable and customary charges. |
| | Specialist visit | $25 co-pay/ visit | 30% co-insurance/ visit | |
| | Other practitioner office visit | •$75 co-pay/ visit for evaluation/ management services only at retail health clinics<br>•50% co-insurance/ visit for family planning/ infertility services<br>•50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery | •Evaluation/management services only at retail health clinics covered at the preferred benefit level<br>•Family planning/ infertility services not covered<br>•50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic 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. Preferred benefit level deductible does not apply.<br>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% co-insurance | 30% co-insurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | $150 co-pay/ service | 30% co-insurance/ service | Prior Approval required for certain radiology examinations.<br>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**<br><br>More information about **prescription drug coverage** is available at https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi | Generic drugs | $10 co-pay/ retail prescription<br>$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 Participating Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90 day supply (mail order prescription)<br>50% co-insurance/ prescription for infertility drugs.<br>Deductible does not apply. |
| | Preferred brand drugs | $40 co-pay/ retail prescription<br>$80 co-pay/ mail order prescription | Not covered | |
| | Non-preferred brand drugs | $80 co-pay/ retail prescription<br>$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) | 10% co-insurance/ visit | 30% co-insurance/ visit | Including outpatient care, observation care and ambulatory surgery center care. Prior approval may be required. |
| | Physician/surgeon fees | 10% co-insurance/ visit | 30% co-insurance/ visit | |
| | Certain Surgeries | 50% co-insurance for each certain surgery | 50% co-insurance for each certain surgery | Coverage includes physicians' fees and any other related charges. Prior approval is required for bariatric surgery, panniculectomy, rhinoplasty, and septorhinoplasty.<br>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 | $150 co-pay/ visit | Covered at the preferred benefit level | Co-pay waived if you become confined in a Hospital as an inpatient. |
| | Emergency medical transportation | $150 co-pay | Covered at the preferred benefit level | ----------none---------- |
| | Urgent care | $75 co-pay/ visit | 30% co-insurance/ visit | Urgent Care services received from a Non-Participating Provider who is located in our Service Area are Covered at the Alternate Benefit level. Urgent Care services received from a Non-Participating Provider who is located outside of our Service Area are Covered at the Preferred Benefit level.<br>Preferred benefit level deductible does not apply. |

| 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) | 10% co-insurance/ visit | 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.<br>Notification must be provided for all admissions following emergency room care. |
| | Physician/surgeon fee | 10% co-insurance/ visit | 30% co-insurance/ visit | |
| | Certain Surgeries | 50% co-insurance for each certain surgery | 50% co-insurance for each certain surgery | Coverage includes physicians' fees and any other related charges.<br>Prior approval is required for bariatric surgery, panniculectomy, rhinoplasty, and septorhinoplasty.<br>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 have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $10 co-pay/ visit | 30% 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.<br>Including medication management visits.<br>Preferred benefit level deductible does not apply. |
| | Mental/Behavioral health inpatient services | 10% co-insurance/ visit | 30% co-insurance/ visit | Including Residential Treatment and partial hospitalization.<br>Except in an emergency, prior approval required. |
| | Substance use disorder outpatient services | $10 co-pay/ visit | 30% co-insurance/ visit | Prior Approval required for intensive outpatient treatment.<br>Including medication management visits.<br>Preferred benefit level deductible does not apply. |
| | Substance use disorder inpatient services | 10% co-insurance/ visit | 30% co-insurance/ visit | Including subacute, Residential Treatment and partial hospitalization.<br>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.<br>Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy. |
| | Delivery and all inpatient services | 10% co-insurance/ visit | 30% co-insurance/ visit | ----------none---------- |

| 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 health needs** | Home health care | No charge | 30% co-insurance/ visit | Including hospice care services; excluding rehabilitation and habilitation services.<br>Prior approval required after the first 30 days of Home health care except for hospice care services in the home.<br>Rehabilitation and habilitation services provided in the home are subject to the limitations of the Rehabilitation Services and Habilitation Services benefits described below.<br>Preferred benefit level deductible does not apply. |
| | Rehabilitation services *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 per contract year.<br>Speech therapy limited to a combined 30 visits per contract year.<br>Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits per contract year.<br>Preferred benefit level deductible does not apply. |
| | Habilitation services for treatment of Autism Spectrum Disorder ***only*** | • $10 co-pay/ visit for Physical, Occupational and Speech Therapy<br>• 10% co-insurance/ visit for Applied Behavioral Analysis (ABA) services | 50% co-insurance/ visit | Prior Approval required for Applied Behavioral Analysis (ABA).<br>Services are Covered for children and adolescents under age 19 only.<br>Multiple charges may apply during one day of service.<br>Preferred benefit level deductible does not apply to flat dollar co-pays. |
| | 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 per contract year. Speech therapy limited to a combined 30 visits per contract year. Deductible does not apply. |
| | Skilled nursing care | 10% co-insurance/ visit | 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.<br>Prior approval required. |
| | Durable medical equipment (DME) | 50% co-insurance/ visit | 50% co-insurance/ visit | Including rental, purchase or repair.<br>Prior Approval required for equipment over $1,000, all rentals and all shoe inserts. |
| | Prosthetics & orthotics | 50% co-insurance/ visit | 50% co-insurance/ visit | |
| | Hospice service | 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.<br>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 frame and one pair of eyeglass lenses or, in lieu of eyeglasses only, 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.<br>Formulary applies. Deductible does not apply. |
| | Child dental check-up | Not covered | Not covered | Not covered |

## 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
- Emergency services provided outside the U.S.
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Routine eye care (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.**
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 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, kwiijigo holne' 1-800-446-5674.

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

## 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 plan's overall deductible | $2,000 |
| Specialist co-insurance | $25 |
| Hospital (facility) co-insurance | 10% |
| Other co-insurance | 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 | $250 |
| Co-payments | $20 |
| Co-insurance | $490 |
| *What isn't covered* | |
| Limits or exclusions | $150 |
| **The total Peg would pay is** | **$910** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist co-insurance | $25 |
| Hospital (facility) co-insurance | 10% |
| Other co-insurance | 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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Co-payments | $500 |
| Co-insurance | $530 |
| *What isn't covered* | |
| Limits or exclusions | $80 |
| **The total Joe would pay is** | **$1,360** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist co-insurance | $25 |
| Hospital (facility) co-insurance | 10% |
| Other co-insurance | 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** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Co-payments | $640 |
| Co-insurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$920** |

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