



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 the number on back of your Priority Health ID card. 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 the number on back of your Priority Health ID card to request a copy.

Important Questions	Answers	Why this Matters
<b>What is the overall deductible?</b>	For Tier 1 <u>participating providers</u> \$650 person / \$1,300 family. For Tier 2 <u>participating providers</u> \$2,000 person / \$4,000 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.
<b>Are there services covered before you meet your deductible?</b>	Yes, the deductible doesn't apply to <u>preventive care</u> .	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$9,100 person / \$18,200 family. Your plan also has a <u>co-insurance</u> maximum For Tier 1 <u>participating providers</u> \$2,000 person / \$4,000 family For Tier 2 <u>participating providers</u> \$3,000 person / \$6,000 family	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 plan, 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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, health care this plan doesn't cover, and services that exceed an annual day/visit limit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See PriorityHealth.com or call the number on back of your Priority Health ID card for a list of <u>participating providers</u> .	You pay the least if you use a <u>provider</u> in Tier 1. You pay more if you use a <u>provider</u> in Tier 2. 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</u> charge and what your plan 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.
<b>Do you need a referral to see a specialist?</b>	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
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 co-pay/ visit	\$35 co-pay/ visit	Not covered	Deductible does not apply.
	Specialist visit	\$40 co-pay/ visit	\$50 co-pay/ visit	Not covered	Deductible does not apply.
	Preventive care/screening/immunization	No charge	No charge	Not covered	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines. Deductible does not apply. 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.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	20% co-insurance	30% co-insurance	Not covered	Prior Authorization may be required.
	Imaging (CT/PET scans, MRIs)	\$150 co-pay	\$150 co-pay	Not covered	Prior Authorization required. Co-pay waived if performed while confined in a hospital as an inpatient. 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
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi">https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi</a>	Generic drugs (Tier 1)	\$15 co-pay/ retail prescription \$30 co-pay/ mail order prescription	\$15 co-pay/ retail prescription \$30 co-pay/ mail order prescription	Not covered	Covers up to a 31-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription, excluding Specialty Drugs). 50% co-insurance/ prescription for infertility drugs. Deductible does not apply.
	Preferred brand drugs (Tier 2)	\$50 co-pay/ retail prescription \$100 co-pay/ mail order prescription	\$50 co-pay/ retail prescription \$100 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	\$100 co-pay/ retail prescription \$200 co-pay/ mail order prescription	\$100 co-pay/ retail prescription \$200 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs (Tier 4)	\$50 co-pay/ retail prescription	\$50 co-pay/ retail prescription	Not covered	Deductible does not apply.
	Non-Preferred specialty drugs (Tier 5)	\$100 co-pay/ retail prescription	\$100 co-pay/ retail prescription	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% co-insurance/ visit	30% co-insurance/ visit	Not covered	Including outpatient care, observation care and ambulatory surgery center care. Prior Authorization may be required.
	Physician/surgeon fees	20% co-insurance/ visit	30% co-insurance/ visit	Not covered	
<b>If you need immediate medical attention</b>	Emergency room services	\$150 co-pay/ visit	Covered at the Tier 1 benefit level	Covered at the Tier 1 benefit level; R&C limitations apply	Co-pay waived if you become confined in a hospital as an inpatient. Deductible does not apply.
	Emergency medical transportation	\$150 co-pay	Covered at the Tier 1 benefit level	Covered at the Tier 1 benefit level; R&C limitations apply	Deductible does not apply.
	Urgent care	\$55 co-pay/ visit	\$65 co-pay/ visit	Covered at the in-network benefit level when obtained outside of the Service Area; R&C limitations apply	Deductible does not apply.

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Common Medical Events	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-insurance/ visit	30% co-insurance/ visit	Not covered	Prior Authorization is required except in emergencies.
	Physician/surgeon fee	20% co-insurance/ visit	30% co-insurance/ visit	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 co-pay/ visit	\$35 co-pay/ visit	Not covered	No charge for first three mental health visits with a participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. Deductible does not apply. Except in an emergency, Prior Authorization required.
	Inpatient services	20% co-insurance/ visit	30% co-insurance/ visit	Not covered	
<b>If you are pregnant</b>	Routine prenatal and postnatal care	No charge	No charge	Not covered	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge may apply to physician office services for complications of pregnancy. Except in an emergency, Prior Authorization required.
	Delivery professional fees	20% co-insurance/ visit	30% co-insurance/ visit	Not covered	
	Delivery facility fees	20% co-insurance/ visit	30% co-insurance/ visit	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).

Common Medical Events	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge	No charge	Not covered	Including hospice care services; excluding rehabilitation and habilitation services. Prior Authorization required, except for hospice care.
	Rehabilitation services	\$25 co-pay/ visit	<ul style="list-style-type: none"> <li>•\$35 co-pay/ visit for Physical, Occupational and Speech Therapy and Cardiac and Pulmonary Rehabilitation</li> <li>•\$25 co-pay/ visit for Osteopathic and Chiropractic Manipulation</li> </ul>	Not covered	Physical and occupational therapy limited to a combined 60 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. Deductible does not apply.
	Habilitation services	<ul style="list-style-type: none"> <li>•\$25 co-pay/ visit for Physical, Occupational and Speech Therapy for the treatment of Autism Spectrum Disorder</li> <li>•20% co-insurance/ visit for Applied Behavior Analysis (ABA) services for the treatment of Autism Spectrum Disorder</li> <li>•\$25 co-pay/ visit for Physical, Occupational and Speech Therapy not for the treatment of Autism Spectrum Disorder</li> </ul>	<ul style="list-style-type: none"> <li>•\$35 co-pay/ visit for Physical, Occupational and Speech Therapy for the treatment of Autism Spectrum Disorder</li> <li>•30% co-insurance/ visit for Applied Behavior Analysis (ABA) services for the treatment of Autism Spectrum Disorder</li> <li>•\$35 co-pay/ visit for Physical, Occupational and Speech Therapy not for the treatment of Autism Spectrum Disorder</li> </ul>	Not covered	Prior Authorization required for Applied Behavior Analysis (ABA). Physical and occupational therapy, not for the treatment of Autism Spectrum Disorder, limited to a combined 60 visits per contract year. Speech therapy, not for the treatment for Autism Spectrum Disorder, limited to a combined 30 visits per contract year. Multiple charges may apply during one day of service. Deductible does not apply to flat dollar co-pays for the treatment of Autism Spectrum Disorder.
	Skilled nursing care	No charge	30% co-insurance/ visit	Not covered	Services limited to a combined 135 days per contract year. Prior Authorization required, except for hospice care.
	Durable medical equipment (DME)	20% co-insurance/ visit	30% co-insurance/ visit	Not covered	Including rental, purchase or repair. Prior Authorization required for equipment over \$1,000 and all rentals.
	Hospice service	No charge	No charge	Not covered	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.
	<b>If your child needs dental or eye care</b>	Child eye exam	Not covered	Not covered	Not covered
Child glasses		Not covered	Not covered	Not covered	Not covered
Child dental check-up		Not covered	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
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Long-term care
- Private-duty nursing
- Dental care (Adult & Child)
- Routine eye care (Adult & Child)
- 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
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Weight loss programs
- Chiropractic care

**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](mailto: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.ccio.cms.gov](http://www.ccio.cms.gov); or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 the number on back of your Priority Health ID card or [www.priorityhealth.com](http://www.priorityhealth.com); the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto: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](mailto: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 número que figura en el reverso de su tarjeta de identificación de salud prioritaria.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa Tagalog, tawagan ang numero sa likod ng iyong Priority Health ID card.

Chinese (中文): 如果您需要中文帮助, 请拨打优先健康身份证背面的电话.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'.

-----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>	\$2,000
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	10%
■ Other <u>co-insurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Co-payments	\$0
Co-insurance	\$2,300
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,360</b>

### 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>	\$2,000
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	10%
■ Other <u>co-insurance</u>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Co-payments	\$1,200
Co-insurance	\$300
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,560</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	10%
■ 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Co-payments	\$0
Co-insurance	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,300</b>

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