PriorityHealth : PriorityPPO 500 2-tier Rx Plan

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

Coverage Period: Beginning on or after 01/01/2016
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 **$500** person / **$1,000** family For non-network providers **$1,000** person / **$2,000** family The network benefits deductible doesn't apply to preventive care, allergy services, home health care, hospice care in the home, pediatric vision services or prescription drugs. The deductible also doesn't apply to any services subject to flat dollar co-pays except emergency room, ambulance and advanced imaging services. These services are subject to both 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 **$5,000** person / **$10,000** family For non-network providers **$10,000** person / **$20,000** family The out-of–pocket limit for each benefit level is calculated separately. If you have more than one person on your plan, only the family out-of-pocket limit applies. The maximum network out-of-pocket limit for any one individual within the family is $5,000. The maximum non-network out-of-pocket limit for any one individual within the family is $10,000.	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, additional costs 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 certain 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**.

Questions: Call **1-888-389-6645** or visit us at **PriorityHealth.com**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform or www.cciio.cms.gov** or call 1-888-389-6645 to request a copy.

- **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	$20 co-pay/ visit	40% 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. A prescription drug co-pay may also apply when selected injectable drugs are provided. Retail service center services are covered at reasonable and customary charges. See the Schedule of Benefits for a complete list of certain surgeries and treatments. Prior Approval may be required. Dietitian services include visits *not* listed in Priority Health's Preventive Health Care Guidelines. These services are limited to 6 visits per contract year. Network benefits deductible does not apply to primary care office visits, specialist office visits, eCare visits, evaluation/management services at retail service centers, allergy services, or dietitian services provided by network providers.
	Specialist visit	$35 co-pay/ visit	40% co-insurance/ visit	
	Other practitioner office visit	• $20 co-pay/ visit for eCare visits • $75 co-pay/visit for evaluation/management services only at retail service centers • $35 co-pay/ visit for dietitian services • No charge for allergy testing, serum & injections • 50% co-insurance/ visit for family planning/ infertility services • 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery • 50% co-insurance for each certain surgery	• eCare visits not covered • Evaluation/management services only at retail service centers covered at the network benefit level • Dietitian services not covered • 40% co-insurance for allergy testing, serum & injections • 50% co-insurance/ visit for family planning/infertility services • 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognatic surgery • 50% co-insurance for each certain surgery	
	Preventive care/screening/ immunization	No charge	40% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Network benefits deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	Appropriate office visit charges (PCP or specialist) may apply for physician office services.
	Imaging (CT/PET scans, MRIs)	$150 co-pay/ service	40% 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) 50% co-insurance/ prescription for infertility drugs. Deductible does not apply. If you choose to receive a brand name drug when an equivalent generic drug is available, you may have to pay the difference in cost between the brand name drug and the generic drug. That additional cost does not apply toward your deductible or out-of-pocket limit. This includes specialty drugs.
	Preferred brand drugs	$40 co-pay/ retail prescription $80 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs	$40 co-pay/ retail prescription $80 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs	$40 co-pay/ retail prescription	Not covered	Deductible does not apply.
	Non-Preferred specialty drugs	$40 co-pay/ 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 approval 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 any other related charges. Prior approval 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	$150 co-pay/ visit	Covered at the network benefit level	Co-pay waived if you become confined in a Hospital as an inpatient within 24 hours.
	Emergency medical transportation	$150 co-pay	Covered at the network benefit level	----------none----------
	Urgent care	$75 co-pay/ visit	40% co-insurance/ visit	Deductible does not apply to services provided by a network provider.

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)	20% co-insurance/ visit	40% 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. 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 any other related charges. Prior approval 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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/ visit	40% co-insurance/ visit	Including medication management visits. Deductible does not apply to services provided by a network provider.
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance/ visit	Including Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
	Substance use disorder outpatient services	$20 co-pay/ visit	40% co-insurance/ visit	Including medication management visits. Deductible does not apply to services provided by a network provider.
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance/ visit	Including subacute, Residential Treatment and partial hospitalization. Except in an emergency, prior approval 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. 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	20% co-insurance/ visit	40% 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	40% co-insurance/ visit	Including hospice care services; excluding rehabilitation and habilitation services. Prior Approval required after the first 30 days of Home Health Care except for Hospice Care services in the home. Rehabilitation 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 to services provided by a network provider.
	Rehabilitation services *not* for the treatment of Autism Spectrum Disorder	$35 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. Speech therapy limited to a combined 30 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits per contract year.
	Habilitation services *not* for the treatment of Autism Spectrum Disorder	$35 co-pay/ visit	50% co-insurance/ visit	Physical and occupational therapy limited to a combined 30 visits per contract year. Speech therapy limited to 30 visits per contract year.
	Habilitation services for treatment of Autism Spectrum Disorder ***only***	• $35 co-pay/ visit for Physical, Occupational and Speech Therapy • 20% co-insurance/ visit for Applied Behavioral Analysis (ABA) services	50% co-insurance/ visit	Prior Approval required for all treatment of Autism Spectrum Disorder. Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service. Deductible does not apply to Physical, Occupational or Speech Therapy provided by a network provider.
	Skilled nursing care	20% co-insurance/ visit	40% 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 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. Deductible does not apply to services provided by a network provider.
If your child needs dental or eye care	Eye exam	No charge	Not covered	One exam per 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 (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 difs-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.

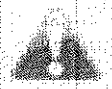
Does this Coverage Meet the Minimum Value Standard?

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** $5,940
- **Patient pays** $1,600

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	$500
Co-pays	$20
Co-insurance	$930
Limits or exclusions	$150
Total	**$1,600**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,690
- **Patient pays** $1,710

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	$500
Co-pays	$580
Co-insurance	$550
Limits or exclusions	$80
Total	**$1,710**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-528-8762.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-528-8762.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-528-8762.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-528-8762.

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.

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