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

Coverage Period: Beginning on or after 01/01/2026

PriorityHealth **: MyPriority Enhanced Gold - Bronson Healthcare Partners**

Coverage for: Subscriber/Dependent | Plan Type: HMO

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 1-800-528-8762. 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 1-800-528-8762 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	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?	$9,200 person / $18,400 family	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, services that exceed an annual day/visit limit, and any co-pays and co-insurance you pay for any non-essential health benefits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. You will receive care within the Bronson Healthcare Partners Network of doctors and hospitals located around Kalamazoo, Calhoun and Van Buren counties. See PriorityHealth.com or call 1-800-528-8762 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 can see an in-network specialist you choose without a referral.

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	Not covered	-----------none-----------
	Specialist visit	$45 co-pay/ visit	Not covered	
	Other practitioner office visit	No charge for limited virtual care services	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. 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)	$45 co-pay	Not covered	Prior authorization may be required. Appropriate office visit co-pay applies for physician office services. Appropriate hospital inpatient or outpatient visit co-pay applies for hospital services.
	Imaging (CT/PET scans, MRIs)	$250 co-pay/ service	Not covered	Prior authorization required.

Common Medical Events	Services You May Need	What You Will Pay: Participating Provider (You will pay the least)	What You Will Pay: Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
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	Not covered	Covers up to a 31-day supply (retail prescription); Specialty drugs may be limited to a 15-day supply. 50% co-insurance/ prescription for infertility drugs. Deductible does not apply to generic drugs only.
	Other generic drugs (Tier 1b)	$20 co-pay/ retail prescription	Not covered	
	Preferred brand drugs (Tier 2)	$75 co-pay/ retail prescription	Not covered	
	Non-Preferred brand drugs (Tier 3)	$100 co-pay/ retail prescription	Not covered	
	Preferred specialty drugs (Tier 4)	50% co-insurance/ retail prescription	Not covered	-----------none-----------
	Non-Preferred specialty drugs (Tier 5)	50% co-insurance/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,000 co-pay/ visit	Not covered	Including outpatient care, observation care and ambulatory surgery center care. Prior authorization may be required.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room services	$250 co-pay/ visit	$250 co-pay/ visit	Co-pay waived if you become confined in a Hospital as an inpatient.
	Emergency medical transportation	$250 co-pay	$250 co-pay	-----------none-----------
	Urgent care	$75 co-pay/ visit	Not covered	-----------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 have a hospital stay	Facility fee (e.g., hospital room)	$1,000 co-pay/ per day up to 5 days	Not covered	Prior authorization is required, except in emergencies.
	Physician/surgeon fee	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$20 co-pay/ visit	Not covered	No charge for first three visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. Deductible does not apply.
	Mental/Behavioral health inpatient services	$1,000 co-pay/ per day up to 5 days	Not covered	Prior authorization is required, except in emergencies.
	Substance use disorder outpatient services	No charge	Not covered	Deductible does not apply.
	Substance use disorder inpatient services	$1,000 co-pay/ per day up to 5 days	Not covered	Prior authorization is required, except in emergencies.
If you are pregnant	Routine prenatal and postnatal care	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.
	Delivery professional fees	No charge	Not covered	-----------none-----------
	Delivery facility fees	$1,000 co-pay/ per day up to 5 days	Not covered	-----------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	$45 co-pay/ visit	Not covered	Excluding rehabilitation and habilitation services. Prior authorization required.
	Rehabilitation services	$45 co-pay/ visit	Not covered	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 30 visits per contract year. Cardiac and pulmonary rehabilitation limited to a combined 30 visits per contract year.
	Habilitation services for treatment of Autism Spectrum Disorder ***only***	• $45 co-pay/ visit for Physical, Occupational and Speech Therapy • $20 co-pay/ visit for Applied Behavior Analysis (ABA) services	Not covered	Prior authorization required for Applied Behavior Analysis (ABA). Multiple charges may apply during one day of service.
	Habilitation services not for the treatment of Autism Spectrum Disorder	$45 co-pay/ visit	Not covered	Physical and occupational therapy limited to a combined 30 visits per contract year. Speech therapy limited to 30 visits per contract year.
	Skilled nursing care	$1,000 co-pay/ per day up to 5 days	Not covered	Services limited to a combined 45 days per contract year. Prior authorization required, except for hospice care services.
	Durable medical equipment (DME)	50% 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	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.
If your child needs dental or eye care	Child eye exam	No charge	Not covered	One exam per year.
	Child glasses	No charge	Not covered	Coverage limited to one pair of glasses per year.
	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	• 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; or 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. 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 1-800-528-8762 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? Not Applicable.

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 1-800-528-8762.

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.

---------------------*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	**$0**
Specialist co-payment	**$45**
Hospital (facility) co-payment	**$1,000**
Other co-insurance	**0%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Co-payments	$2,600
Co-insurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$0**
Specialist co-payment	**$45**
Hospital (facility) co-payment	**$1,000**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Co-payments	$1,500
Co-insurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

Mia's Simple Fracture

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

The plan's overall deductible	**$0**
Specialist co-payment	**$45**
Hospital (facility) co-payment	**$1,000**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Co-payments	$1,400
Co-insurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

MyPriority HMO℠— Zero Cost Share for Limited Services

If you are an American Indian or a Native Alaskan, and the Marketplace determines you meet certain eligibility requirements, you do not have to pay your deductible, co-pays or co-insurance for a limited number of services.

Important information	Answers
What is the zero cost share provision?	The zero cost share provision exempts certain items or services from the deductible, co-pays or co-insurance of your plan when they are provided: • directly to you by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization; or • through referral under contract health services.
How does zero cost share work?	• If the Provider (Indian Health Service, Indian Tribe, Tribal Organization, Urban Indian Organization, or the provider you see through referral under contract health services) is a Participating Provider, there is no charge. • If the Provider (Indian Health Service, Indian Tribe, Tribal Organization, Urban Indian Organization, or the provider you see through referral under contract health services) is a Non-Participating Provider, there is no charge up to a Reasonable and Customary amount.
What are the limitations?	• Services must be Medically/Clinically necessary • Services will count toward the same day and/or visit limitations as the services not covered under the zero cost share provision. See your plan documents for additional information.
What is Reasonable and Customary?	**Reasonable and Customary** is the charge for covered services which is the lower of: (a) the Providers usual charge for any covered service; or (b) the charge we determine to be the prevailing charge level for any covered service. See your plan documents for additional information.

You can learn more online at *priorityhealth.com*. Or call the phone number on the back of your Priority Health ID card.