Schedule of Copayments and Deductibles
My**Priority** SM – Enhanced Gold – Southeast Michigan Network

Important: You will receive care within the Southeast Michigan Network of doctors and hospitals located around Oakland, Macomb and Wayne counties. Your Primary Care Provider (PCP) will coordinate your care. Other than eligible emergency services, care outside the Southeast Michigan Network is not covered. Use our Find a Doctor tool at *priorityhealth.prismisp.com* to see if your PCP is in the Southeast Michigan HMO Network.

Your Agreement provides you with important information about your health care benefits, including Prior Authorization requirements. This Schedule of Copayments and Deductibles provides you with information about your costs when you receive health care services and the maximum limitations of your health care benefits. Read the entire Agreement, Schedule of Copayments and Deductibles and any plan Riders carefully.

In accordance with the terms and conditions of the Agreement, you are entitled to Covered Services when these services are:

A. Medically/Clinically Necessary (as defined in the Agreement and according to Medical and Behavioral Health policies established by Priority Health with the input of Physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health); and

B. Provided by your PCP or provided by a Participating Provider and with authorization in advance by us when we consider authorization necessary (except in a Medical Emergency) or provided by a Non-Participating Provider (one not listed in our Provider Directory) upon referral from your PCP and authorized in advance by us (except in a Medical Emergency); or

C. Provided by a Retail Health Clinic located within the United States; or

D. Provided outside of the Service Area, but within the United States, to a Covered Dependent child who resides outside the Service Area (Reasonable and Customary limitations apply); and

E. Not excluded in the Agreement or in a Rider or an amendment to the Agreement.

See Section 6 of your Agreement for Covered and Non-Covered Services, including the summary of Covered preventive health care services. Priority Health's complete Preventive Health Care Guidelines are available in our Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department.

PRIOR AUTHORIZATION

Prior Authorization is required before you may obtain certain services. If you seek services that require Prior Authorization, without receiving Prior Authorization from us, you will be responsible for the full cost of those services. You will also be responsible for the full cost of services that are beyond those authorized, beyond the benefit maximums or excluded from Coverage.

The complete and detailed list of services that require Prior Authorization is available by calling our Customer Service Department or on our website at *priorityhealth.com*. This list may change throughout the Contract Year as new technology and standards of care emerge.

You or your Physician must call 800.269.1260 to obtain Prior Authorization for services. Emergency admissions must be reported to us as soon as reasonably possible after admission.

DEDUCTIBLE AND OUT-OF-POCKET LIMITS

A. Deductibles:

The Deductible is the amount you must pay for Covered Services during the Contract Year before benefits will be paid. Your Deductibles are described in the chart below.

Deductibles	
Individual Contract	Not Applicable
Family Contract	Not Applicable

B. Out-of-Pocket Limits:

The Out-of-Pocket Limit is the total amount of Copayments and Coinsurance for medical and prescription drug Covered Services that you will pay during a Contract Year. Your cost sharing Out-of-Pocket Limit applies to Covered Services except those listed below.

Out-of-Pocket Limits	
Individual Contract	$ 9,200.00
Family Contract	$18,400.00 (but not to exceed $9,200.00 per person)

Amounts you pay for any of the following will *not* apply toward the Out-of-Pocket Limits.

- any monies you paid for failure to obtain Prior Authorization when necessary; and
- any monies you paid for Non-Covered Services; and
- any monies you paid for Covered Services that exceed the annual day or visit benefit maximum for a specific benefit and therefore, denied as Non-Covered Services.

Note: Copayments and Coinsurance you pay for any non-essential health benefit Covered Services obtained under a supplemental benefit Rider may not be applied toward the above Out-of-Pocket Limit.

Covered Benefits

PROVIDER-BASED FACILITY FEES (Includes fees that may be charged for services provided by support staff, use of the room and equipment) (See Hospital Services section below for additional information)	
Services	**Benefits**
Preventive Health Care Services	100% Coverage
Office-Based Services	See Hospital Outpatient Care and Hospital Observation Care Services section below
PREVENTIVE HEALTH CARE BENEFITS	
Preventive Health Care Services (See Section 6.A.1 of your Agreement for the summary of Covered preventive health care services)	100% Coverage
PROFESSIONAL SERVICES (Primary and Referral Care) (See Other Services sections below for additional Copayment information)	
Office/Home Visits - Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits)	• $20.00 Copayment per PCP visit, for all Covered Services performed and billed by your PCP during each visit • $45.00 Copayment per other Participating Physician visit, for all Covered Services performed during each visit • Prescription drug Copayment may also apply when selected injectable drugs are provided
Limited Virtual Care Services (Corewell Health Virtual Urgent Care)	100% Coverage
Retail Health Clinic Visits (Located within the United States)	$75.00 Copayment per visit for evaluation and management services only
Inpatient Hospital Visits	See Hospital Inpatient Care and Inpatient Longterm Acute Care Services below
Ambulatory Surgery Center Services	See Hospital Outpatient Care and Hospital Observation Care Services below
Allergy Testing	$250.00 Copayment per test
Allergy Injections and Serum	See Office Visits above
Maternity Services	• Routine prenatal and postnatal visits are Covered under Preventive Health Care Services category above • Attendance at an approved maternity education program is Covered in full. • Visits and consultations for Complications of Pregnancy are Covered as described under the Office Visits category above • See Hospital Services section for facility Coverage related to maternity services, including delivery and nursery services
Family Planning and Infertility Services (Limited Services)	• 50% Coverage for diagnostic, counseling and planning services for treatment of the underlying cause of infertility

Services	Benefits
Tubal Ligation	**Covered under Preventive Health Care Services as follows:** • Physician services and outpatient facility charges are Covered under Preventive Health Care Services above • See Hospital Inpatient Care and Inpatient Longterm Acute Care Services below when in connection with delivery or other Covered inpatient surgery
Vasectomy	• See Office Visits above for Physician services when performed in Physician's office • See Hospital Outpatient Care and Hospital Observation Care Services below when services are performed in an outpatient facility
Temporomandibular Joint Dysfunction or Syndrome	50% Coverage
Orthognathic Surgery	50% Coverage
CERTAIN SURGERIES AND TREATMENTS	
Certain Surgeries and Treatments • Bariatric Surgery • Reconstructive surgery o Blepharoplasty of upper lids o Breast reduction o Panniculectomy o Rhinoplasty o Septorhinoplasty o Surgical treatment of male gynecomastia • Skin disorder treatments o Scar revisions o Keloid scar treatment o Treatment of hyperhidrosis o Excision of lipomas o Excision of seborrheic keratoses o Excision of skin tags o Treatment of vitiligo o Port wine stain and hemangioma treatment • Varicose veins treatments	• 50% Coverage (including Physicians' fees and any other related charges) • Flat dollar Copayments for any related Hospital Inpatient Care Services, Hospital Outpatient Care Services (including ambulatory surgery center facility charges) also apply • Prior Authorization required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and varicose veins treatment. • **Coverage is limited to one bariatric surgery per lifetime. Unless Medically/Clinically Necessary, a second bariatric surgery is <u>not</u> Covered, even if the initial bariatric surgery occurred prior to Coverage under this plan.**

Services	Benefits
HOSPITAL SERVICES (Including radiology examinations and laboratory services)	
Hospital Inpatient Care and Inpatient Longterm Acute Care Services (Including professional fees)	• $1,000.00 Copayment per day (maximum 5 Copayments) • Prior Authorization required at least five 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 required for admissions following emergency room care
Hospital Outpatient Care and Hospital Observation Care Services (Including ambulatory surgery center facility charges and professional fees)	• $1,000.00 Copayment per visit • Some services may require Prior Authorization, including certain radiology examinations
MEDICAL EMERGENCY SERVICES	
Emergency Room Services **Note:** If you are admitted for Hospital Inpatient Care or Hospital Observation Care from the emergency room, your emergency room charges will be paid under the Hospital Services categories above.	• $250.00 Copayment per visit (waived if admitted to the hospital as an inpatient), then subject to: • Reasonable and Customary limitations apply for emergency room services provided by a Non-Participating Provider
Urgent Care Center Services	• $75.00 Copayment per visit • Reasonable and Customary limitations apply for Urgent Care Center services provided by a Non-Participating Urgent Care Center outside the Service Area. Urgent Care Center services by a Non-Participating Provider in the Service Area are *not* Covered.
Ambulance Services (air or ground)	• $250.00 Copayment • Reasonable and Customary limitations apply for ambulance services provided by a Non-Participating Provider
BEHAVIORAL HEALTH SERVICES **When Prior Authorization is required under this section, Call our Behavioral Health Department at 616.464.8500 or 800.673.8043**	
Mental Health Inpatient Care (Including Residential Treatment facility and partial hospitalization)	• $1,000.00 Copayment per day (maximum 5 Copayments) • Prior Authorization required at least five working days in advance, except in emergencies. • Notification required for admissions following emergency room care
Mental Health Outpatient Care - Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits)	• 100% Coverage for first three visits within 90 days of discharge for mental health inpatient care • $20.00 Copayment for all other visits

Services	Benefits
Substance Use Disorder Inpatient Care (Including subacute Residential Treatment facility and partial hospitalization)	• $1,000.00 Copayment per day (maximum 5 Copayments) • Prior Authorization required at least five working days in advance, except in emergencies. • Notification required for admissions following emergency room care
Substance Use Disorder Outpatient Care - Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits)	100% Coverage
REHABILITATION, HABILITATION and DEVICES	
Rehabilitative Medicine Services	
Physical and Occupational Therapy	$45.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year*
Osteopathic and Chiropractic Manipulation Therapy (Includes maintenance visits)	$45.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year*
Speech Therapy	$45.00 Copayment per visit up to a benefit maximum of 30 visits per Contract Year*
Cardiac Rehabilitation and Pulmonary Rehabilitation	$45.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year*
Habilitation Services for the Treatment of Autism Spectrum Disorder	
Physical and Occupational Therapy for the treatment of Autism Spectrum Disorder	$45.00 Copayment per visit
Speech Therapy for the treatment of Autism Spectrum Disorder	$45.00 Copayment per visit
Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder	• $20.00 Copayment per visit • Prior Authorization required for Applied Behavior Analysis (ABA)
Habilitation Services *(not related to Autism Spectrum Disorder)*	
Physical and Occupational Therapy	$45.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year*
Speech Therapy	$45.00 Copayment per visit up to a benefit maximum of 30 visits per Contract Year*

Services	Benefits
Devices	
Durable Medical Equipment (DME) (rent, purchase or repair) **Note:** See Diabetes Services and Supplies category below.	• 50% Coverage • Prior Authorization required for devices over $1,000.00 and all rentals
Prosthetic and Orthotic/Support Devices	• 50% Coverage • Prior Authorization required for devices over $1,000.00 and all shoe inserts
OTHER SERVICES	

Diabetes Services and Supplies (Including education classes furnished by a Participating Provider; and select diabetes supplies when purchased by a Participating DME provider)	• 100% Coverage for education classes furnished by a Participating Provider
	• 100% Coverage for the following diabetes supplies:
	  ○ blood glucose monitors
	  ○ syringes, needles, lancets and blood glucose test strips
	  ○ insulin pumps
	  ○ shoe inserts for members with peripheral neuropathy, including diabetic neuropathy
	  ○ special shoes prescribed for a person with diabetes when Medically/Clinically Necessary according to the criteria set form in our medical policies
	• Prior Authorization required for devices over $1,000.00 and all shoe inserts

Advanced Diagnostic Imaging Services (such as CT, CTA, MRI, MRA, Nuclear Cardiology Studies, PET Scan)	• $250.00 Copayment per advanced imaging service (Copayment waived if performed while confined in a Hospital as an inpatient) • Prior Authorization required
Standard Radiology Examinations and Laboratory Procedures (In a free-standing non-Hospital facility)	• $45.00 Copayment per visit • Prior Authorization required for genetic testing • Professional fee associated with laboratory procedures or standard radiology examinations are Covered in full
Non-Acute Hospital Facility Services Including Skilled Nursing Care services received in a: • Skilled Nursing Care facility • Subacute facility • Inpatient Rehabilitation Care facility • Hospice Care facility	• $1,000.00 Copayment per day (maximum of 5 Copayments) up to a combined benefit maximum of 45 days per Contract Year (except for Hospice Care services in a Hospice Care facility) • Prior Authorization required, except for Hospice Care services in a Hospice Care Facility
Hospice Care in the Home	Covered in full
Home Health Care (Excluding Hospice care, Rehabilitative Medicine Services and Habilitation Services) **Note:** Rehabilitative Medicine Services and Habilitation Services provided in the home are subject to the limitations of the Rehabilitative Medicine Services and Habilitation Services benefits described above.	• $45.00 Copayment per visit • Prior Authorization required

MAXIMUM LIMITATIONS

* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits per Contract Year apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

PEDIATRIC VISION SERVICES (for Members under the age of 19 only)	
Services	**Benefit**
Vision Exam, including dilation if professionally indicated	• Covered in Full up to one exam per Contract Year
Select Eyeglass Frames (Wire, Plastic or Metal)	• Covered in Full up to one frame per Contract Year
Eyeglass Lenses	• Covered in Full up to one pair per Contract Year
Contact Lenses – In Lieu of Eyeglass Frames and Eyeglass Lenses (Includes contact lens materials only)	• Covered in Full for provider designated lenses up to a benefit maximum of: o six month supply of monthly or 2-week disposable single vision spherical or toric contact lenses per Contract Year; or o three month supply of daily disposable, single vision spherical contact lenses per Contract Year o one pair of single vision conventional contact lenses

MEDICAL PHARMACY SERVICES	
In general, Covered drugs are treated as medical benefits when administered in an inpatient or emergency setting, or when the drug requires injection or infusion by a Health Professional. Exceptions to this rule are outlined in our medical policies. The Deductible applies to these pharmacy services provided as a Covered medical service.	
Services	**Benefits**
Drugs Requiring Administration by a Health Professional (injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility) Prior Authorization or step therapy may be required before drug will be Covered. **Specialty Drug -** Drugs listed on the Approved Drug List meeting certain criteria, such as: • drugs or drug classes whose cost on a per- month or per-dose basis exceeds the threshold established by the Centers for Medicare and Medicaid Services; or • drugs that require special handling or administration; or • drugs that have limited distribution; or • drugs in selected therapeutic categories. **Specialty Pharmacy -** A Pharmacy that specializes in the handling, distribution, and patient management of Specialty Drugs.	• 50% Coverage for a Preferred Specialty Drug • 50% Coverage for a Non-Preferred Specialty Drug • Prior Authorization required • Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy

PRESCRIPTION DRUG BENEFITS - RETAIL PHARMACY

Retail Pharmacy Services. Prescription drugs obtained at a retail Participating Pharmacy dispensed in a 31-day supply per prescription or refill). In general, Covered retail pharmacy drugs are treated as outpatient prescription drug benefits when they can be self-administered regardless of the setting. Exceptions to this rule are outlined in our medical policies.

Specialty Drugs may be dispensed in a 15-day supply per prescription or refill.

Prior Authorization or step therapy may be required.

Prescription drugs for the treatment of a chronic condition (for example, high blood pressure) can be refilled for up to a maximum of one year from the last visit with your PCP or prescribing Specialist.

Note:

- If you elect to receive a Brand Name Drug when the prescription allows a Generic Drug substitution, you may be responsible for the difference in cost between the Generic Drug and the Brand Name Drug. Any monies you paid for the difference in cost between a Generic Drug and the Brand Name Drug because you elected to receive a Brand Name Drug when the prescription allows a Generic Drug substitution are Non-Covered Services.
- If you elect to receive a Non-Preferred Drug when the prescription allows a Preferred Drug substitution, you may be responsible for any difference in cost between the Non-Preferred Drug and the base price for that class of drugs. Please visit https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi for more information on drug prices and your benefit. Any monies you paid for the difference in cost between a Preferred Drug and the Non-Preferred Drug, because you elected to receive a Non-Preferred Drug when the prescription allows a Preferred Drug substitution, are Non-Covered Services.
- Pharmacy Services listed in the Preventive Health Care Guidelines, including women's contraceptive services, are covered in full under Preventive Health Care Services.

For more information, see **Outpatient Prescription Drugs** benefit description in Section 6 of your Agreement.

Approved Drug List. A list of Covered drugs that identifies tier placement and any utilization management (such as Prior Authorization, step therapy, and quantity limits) that are required. Tier placement determines what you pay for the drug, outlined below:

Tier 1a: The least expensive prescription drugs available to you. This tier includes low-cost Generic Drugs—proven to be as safe as Brand Name Drugs—and, on some formularies, select Brand Name Drugs.

Tier 1b: This tier includes low-cost Generic Drugs—proven to be as safe as Brand Name Drugs—and, on some formularies, select Brand Name Drugs.

Tier 2: Includes preferred and lower cost Brand Name Drugs, and some higher cost Generic Drugs. If you must take a Brand Name Drug, we recommend working with your Provider to choose one that is Covered here, and the most affordable.

Tier 3: Non-preferred and expensive Brand Name Drugs, as well as higher-cost Generic Drugs. These drugs may cost you a significant amount out of pocket, so we recommend asking your Provider if a tier 1 or 2 option can be prescribed instead.

Tier 4: Includes very expensive Brand Name and Generic Drugs, and preferred Specialty Drugs used to treat complex conditions. Specialty Drugs often have high costs and may have special handling or storage requirements. They are usually dispensed by trained personnel at Specialty Pharmacies. If you need to take a Specialty Drug, we recommend working with your Provider to choose one that is Covered here.

Tier 5: Non-preferred Specialty Drugs, and the most expensive Brand Name and Generic Drugs are Covered here because they offer limited clinical value. Most have a similar lower-cost option offering the same clinical value on tiers 1 through 4. We recommend asking your Provider about alternatives.

Services	Benefits
Tier 1a	$5.00 Copayment per prescription
Tier 1b	$20.00 Copayment per prescription
Tier 2	$75.00 Copayment per prescription
Tier 3	$100.00 Copayment per prescription
Tier 4	50% Copayment per prescription
Tier 5	50% Copayment per prescription
Infertility Drugs	50% Copayment per prescription

EXPANDED CHRONIC CONDITION SERVICES, SUPPLIES and PRESCRIPTION DRUGS FOR NON-HIGH DEDUCTIBLE HEALTH PLANS

The following Coverage is subject to all of the terms and conditions in your Agreement, including your Schedule of Copayments and Deductibles and any Riders or amendments, as well as the terms and conditions set forth in this summary.

COVERED SERVICES for MyPriority Enhanced Gold Plan

The Deductible does *not* apply for the following expanded chronic condition services only. Coverage is subject to Member cost sharing as described below.

- **Blood pressure monitor for Members diagnosed with hypertension when dispensed by a Participating Durable Medical Equipment (DME) Provider.**
  50% Coverage
- **Retinopathy screening for Members diagnosed with diabetes.**
  $45.00 Copayment
- **Hemoglobin A1c testing for Members diagnosed with diabetes.**
  100% Coverage
- **Peak flow meter for Members diagnosed with asthma when dispensed by a Participating Durable Medical Equipment (DME) Provider.**
  100% Coverage
- **International Normalized Ratio (INR) testing for Members diagnosed with liver disease and/or bleeding disorders.**
  $45.00 Copayment
- **Low-Density Lipoprotein (LDL) testing for Members diagnosed with heart disease.**
  100% Coverage
- **Certain drugs. Please contact Customer Service or visit *priorityhealth.com* for a list of these drugs.**
  Applicable Copayments described under the Prescription Drug benefit will apply.

Your Deductible will not take into account any Copayments or Coinsurance you pay for Covered Services under this plan for expanded chronic condition services, supplies and prescription drugs.

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