

Schedule of Copayments and Deductibles

MyPrioritySM Premier Silver – Corewell Health West Michigan Network

70% HOSPITAL SERVICES PLAN

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

Emergency admissions must be reported to us as soon as reasonably possible after admission.

DEDUCTIBLE AND OUT-OF-POCKET LIMITS**B. Deductibles:**

The Deductible is the amount you must pay for Covered Services during the Contract Year before benefits will be paid. The Deductible is applicable to all Covered Services except:

- Preventive health care services listed in Priority Health's Preventive Health Care Guidelines that are designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability; and
- PCP and Specialist visits, Virtual Care services, Retail Health Clinics visits, Urgent Care Center visits, Standard Radiology Examinations and Laboratory Procedures; and
- Pediatric vision services; and
- Prescription Generic and Brand Name Drugs provided at a retail Pharmacy.

See Section 6.A.1 of your Agreement for the summary of Covered preventive health care services.

Deductibles	
Individual Contract	\$ 5,500.00
Family Contract	\$11,000.00 (but not to exceed \$5,500.00 per person)

The following out-of-pocket Member costs do *not* apply towards the Deductibles:

- 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.

Deductible amounts you pay are included in your Out-of-Pocket Limit.

The Deductible renews each Contract Year. Deductible amounts do not carry over into a new Contract Year.

B. Out-of-Pocket Limits:

The Out-of-Pocket Limit applies to certain services. The Out-of-Pocket Limit caps the total amount of Covered benefit expenses that you or your Covered Dependents will pay during a Contract Year, except as described below. Once the Out-of-Pocket Limit is met, all further medical Covered Services for that Contract Year will be paid at 100% of Priority Health's contracted rate.

Out-of-Pocket Limits	
Individual Contract	\$ 9,500.00
Family Contract	\$19,000.00 (but not to exceed \$9,500.00 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: Deductibles, 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 • Deductible does <i>not</i> apply
Office-Based Services	• See Hospital Outpatient Care and Hospital Observation Care Services section below • Deductible applies
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 • Deductible does <i>not</i> apply
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)	• \$30.00 Copayment per PCP visit • \$60.00 Copayment per other Participating Physician visit, including Specialist Provider • Deductible does <i>not</i> apply • Deductible and prescription drug Copayment may also apply when selected injectable drugs are provided
Limited Virtual Care Services (Corewell Health Virtual Urgent Care)	• 100% Coverage • Deductible does <i>not</i> apply
Retail Health Clinic Visits (Located within the United States)	• \$75.00 Copayment per visit for evaluation and management services only • Deductible does <i>not</i> apply
Inpatient Hospital Visits	• 70% Coverage • Deductible applies
Ambulatory Surgery Center Services	• 70% Coverage for Physician surgical charges • Deductible applies
Allergy Testing and Serum	• 70% Coverage • Deductible applies
Allergy Injections	• 70% Coverage • Deductible applies
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. Deductible does <i>not</i> apply. • Visits and consultations for Complications of Pregnancy are Covered as described under the Office Visits category above

Services	Benefits
	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 - Deductible applies
Tubal Ligation	Covered under Preventive Health Care Services as follows: 100% Coverage for Physician services 100% Coverage for outpatient facility charges - Deductible does <i>not</i> apply Note: Hospital Inpatient Care facility charges are subject to Deductible and Coinsurance when in connection with delivery or other Covered inpatient surgery
Vasectomy	70% Coverage - Deductible applies
Temporomandibular Joint Dysfunction or Syndrome	50% Coverage - Deductible applies
Orthognathic Surgery	50% Coverage - Deductible applies
CERTAIN SURGERIES AND TREATMENTS	
Certain Surgeries and Treatments - Bariatric Surgery - Reconstructive surgery - Blepharoplasty of upper lids - Breast reduction - Panniculectomy - Rhinoplasty - Septorhinoplasty - Surgical treatment of male gynecomastia - Skin disorder treatments - Scar revisions - Keloid scar treatment - Treatment of hyperhidrosis - Excision of lipomas - Excision of seborrhic keratoses - Excision of skin tags - Treatment of vitiligo - 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 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. - Deductible applies

Services	Benefits
HOSPITAL SERVICES (Including radiology examinations and laboratory services)	
Hospital Inpatient Care and Inpatient Longterm Acute Care Services	• 70% Coverage • Prior Authorization required, 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 • Deductible applies
Hospital Outpatient Care and Hospital Observation Care Services (Including ambulatory surgery center facility charges)	• \$1,000.00 Copayment for outpatient surgery services, then 70% Coverage of the charge balance • 70% Coverage for all other Hospital Outpatient Care and Hospital Observation Care • Some services may require Prior Authorization • Deductible applies
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: • 70% Coverage • Reasonable and Customary Charge limitations apply for emergency room services provided by a Non-Participating Provider • Deductible applies
Urgent Care Center Services	• \$75.00 Copayment per visit • Reasonable and Customary Charge 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 <i>not</i> Covered. • Deductible does <i>not</i> apply
Ambulance Services (air or ground)	• \$250.00 Copayment per one-way trip, then subject to: • 70% Coverage • Reasonable and Customary Charge limitations apply for ambulance services provided by a Non-Participating Provider • Deductible applies
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)	• 70% Coverage • Prior Authorization required, except in emergencies. • Notification required for admissions following emergency room care • Deductible applies
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 • 100% Coverage for the first visit not related to an inpatient stay • \$30.00 Copayment for all other visits • Deductible does <i>not</i> apply

Services	Benefits
Substance Use Disorder Inpatient Care (Including subacute Residential Treatment facility and partial hospitalization)	• 70% Coverage • Prior Authorization required, except in emergencies. • Notification required for admissions following emergency room care • Deductible applies
Substance Use Disorder Outpatient Care – Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits)	• 100% Coverage • Deductible does <i>not</i> apply
REHABILITATION, HABILITATION and DEVICES	
Rehabilitative Medicine Services	
Physical and Occupational Therapy	• 70% Coverage up to a combined benefit maximum of 30 visits per Contract Year* • Deductible applies
Osteopathic and Chiropractic Manipulation Therapy (Includes maintenance visits)	• 70% Coverage up to a combined benefit maximum of 30 visits per Contract Year* • Deductible applies
Speech Therapy	• 70% Coverage up to a benefit maximum of 30 visits per Contract Year* • Deductible applies
Cardiac Rehabilitation and Pulmonary Rehabilitation	• 70% Coverage up to a combined benefit maximum of 30 visits per Contract Year* • Deductible applies
Habilitation Services for the Treatment of Autism Spectrum Disorder	
Physical and Occupational Therapy for the treatment of Autism Spectrum Disorder	• 70% Coverage • Deductible applies
Speech Therapy for the treatment of Autism Spectrum Disorder	• 70% Coverage • Deductible applies
Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder	• \$30.00 Copayment per visit • Prior Authorization required for Applied Behavior Analysis (ABA) • Deductible does <i>not</i> apply
Habilitation Services (<i>not related to Autism Spectrum Disorder</i>)	
Physical and Occupational Therapy	• 70% Coverage up to a combined benefit maximum of 30 visits per Contract Year* • Deductible applies
Speech Therapy	• 70% Coverage up to a benefit maximum of 30 visits per Contract Year* • Deductible applies

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 • Deductible applies
Prosthetic and Orthotic/Support Devices	• 50% Coverage • Prior Authorization required for devices over \$1,000.00 and all shoe inserts • Deductible applies
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 in our medical policies • Prior Authorization required for devices over \$1,000.00 and all shoe inserts • Deductible does <i>not</i> apply
Advanced Diagnostic Imaging Services (such as CT, CTA, MRI, MRA, Nuclear Cardiology Studies, PET Scan)	• \$150.00 Copayment per imaging service, then subject to: • 70% Coverage • Prior Authorization required • Deductible applies
Standard Radiology Examinations and Laboratory Procedures (In a Physician's office, Hospital Outpatient setting or free-standing non-Hospital facility) - Includes services <i>not</i> Covered under Preventive Health Care Services	• \$15.00 Copayment per service for laboratory procedures. Deductible does <i>not</i> apply. • 70% Coverage per visit for standard radiology examinations. Deductible applies. • Prior Authorization required for genetic testing
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	• 70% Coverage 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 • Deductible applies

Services	Benefits
Home Health Care (Including Hospice Care services in the home, excluding 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.	• 70% Coverage • Prior Authorization required, except for Hospice Care services in the home • Deductible applies

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 • Deductible does <i>not</i> apply
Select Eyeglass Frames (Wire, Plastic or Metal)	• Covered in Full up to one frame per Contract Year • Deductible does <i>not</i> apply
Eyeglass Lenses	• Covered in Full up to one pair per Contract Year • Deductible does <i>not</i> apply
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: ○ six month supply of monthly or 2-week disposable single vision spherical or toric contact lenses per Contract Year; or ○ three month supply of daily disposable, single vision spherical contact lenses per Contract Year ○ one pair of single vision conventional contact lenses • Deductible does <i>not</i> apply

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 • Deductible applies

PRESCRIPTION DRUG BENEFITS – RETAIL PHARMACY

The Deductible applies to Covered retail pharmacy services as detailed below.

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.

Schedule of Copayments and Deductibles

Services	Benefits
Tier 1a	• \$5.00 Copayment per prescription • Deductible does <i>not</i> apply
Tier 1b	• \$20.00 Copayment per prescription • Deductible does <i>not</i> apply
Tier 2	• \$75.00 Copayment per prescription • Deductible does <i>not</i> apply
Tier 3	• \$125.00 Copayment per prescription • Deductible does <i>not</i> apply
Tier 4	• 50% Copayment per prescription • Deductible applies
Tier 5	• 50% Copayment per prescription • Deductible applies
Infertility Drugs	• 50% Copayment per prescription • Deductible applies

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 Premier Silver 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 and hemoglobin A1c testing for Members diagnosed with diabetes.**
\$10 Copayment
- **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.**
\$10 Copayment
- **Low-Density Lipoprotein (LDL) testing for Members diagnosed with heart disease.**
\$10 Copayment
- **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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