PriorityHealth : **MyPriority Premier Silver**
**94% Cost Share Reduction**

**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?** | $450 person / $900 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes, the deductible doesn't apply to preventive care or pediatric vision services. | 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?** | $1,200 person / $2,400 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. 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 | $5 co-pay/ visit | Not covered | Deductible does not apply to office visits or limited virtual care services. |
| | Specialist visit | $10 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. Deductible does not apply.<br>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) | • $5 co-pay/ lab services<br>• 10% co-insurance/ radiology services | Not covered | Prior authorization may be required.<br>Deductible does not apply to laboratory services.<br>Appropriate hospital inpatient visit charges apply for inpatient hospital services. |
| | Imaging (CT/PET scans, MRIs) | 10% co-insurance | Not covered | Prior authorization required. |

| 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 drugs to treat your illness or condition**<br><br>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.<br>50% co-insurance/ prescription for infertility drugs.<br>Deductible does not apply to generic and brand name drugs only. |
| | Other generic drugs (Tier 1b) | $5 co-pay/ retail prescription | Not covered | |
| | Preferred brand drugs (Tier 2) | $15 co-pay/ retail prescription | Not covered | |
| | Non-Preferred brand drugs (Tier 3) | $25 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) | $500 co-pay/ visit, 10% co-insurance | Not covered | Including outpatient care, observation care and ambulatory surgery center care. Prior authorization may be required. |
| | Physician/surgeon fees | 10% co-insurance/ visit | Not covered | |
| **If you need immediate medical attention** | Emergency room services | 10% co-insurance/ visit | 10% co-insurance/ visit | -----------none----------- |
| | Emergency medical transportation | 10% co-insurance | 10% co-insurance | -----------none----------- |
| | Urgent care | $75 co-pay/ visit | Not covered | Deductible does not apply. |

| 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) | 10% co-insurance/ visit | Not covered | Prior authorization is required, except in emergencies. |
| | Physician/surgeon fee | 10% co-insurance/ visit | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Mental/Behavioral health outpatient services | $5 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.<br>No charge for first visit not related to inpatient stay.<br>Deductible does not apply. |
| | Mental/Behavioral health inpatient services | 10% co-insurance/ visit | 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 | 10% co-insurance/ visit | 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.<br>Appropriate office visit charge may apply to physician office services for complications of pregnancy. |
| | Delivery professional fees | 10% co-insurance/ visit | Not covered | -----------none----------- |
| | Delivery facility fees | 10% co-insurance/ visit | Not covered | -----------none----------- |

| 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 help recovering or have other special health needs** | Home health care | 10% co-insurance/ visit | Not covered | Including hospice care services; excluding rehabilitation and habilitation services.<br>Prior authorization required, except for hospice care services. |
| | Rehabilitation services | 10% co-insurance/ visit | Not covered | Physical and occupational therapy limited to a combined 30 visits per contract year.<br>Osteopathic and chiropractic manipulation limited to a combined 30 visits per contract year.<br>Speech therapy limited to 30 visits per contract year.<br>Cardiac and pulmonary rehabilitation limited to a combined 30 visits per contract year. |
| | Habilitation services for treatment of Autism Spectrum Disorder ***only*** | • 10% co-insurance/ visit for Physical, Occupational and Speech Therapy<br>• $5 co-pay/ visit for Applied Behavior Analysis (ABA) services | Not covered | Prior authorization required for Applied Behavior Analysis (ABA).<br>Multiple charges may apply during one day of service.<br>Deductible does not apply to ABA services. |
| | Habilitation services not for the treatment of Autism Spectrum Disorder | 10% co-insurance/ 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 | 10% co-insurance/ visit | Not covered | Services limited to a combined 45 days per contract year.<br>Prior authorization required, except for hospice care services. |
| | Durable medical equipment (DME) | 50% co-insurance/ visit | Not covered | Including rental, purchase or repair.<br>Prior authorization required for equipment over $1000 and all rentals. |
| | Hospice service | 10% co-insurance/ visit | 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. Deductible does not apply. |
| | Child glasses | No charge | Not covered | Coverage limited to one pair of glasses per year.<br>Deductible does not apply. |
| | 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<br>• Cosmetic surgery<br>• Dental care (Adult & Child) | • Hearing aids<br>• Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Private-duty nursing<br>• Routine eye care (Adult)<br>• 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<br>• Chiropractic care | • Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility | • Routine eye care (Child)<br>• 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** **$450**
- **Specialist co-payment** **$10**
- **Hospital (facility) co-insurance** **10%**
- **Other co-insurance** **10%**

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $450 |
| Co-payments | $100 |
| Co-insurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,210** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$450**
- **Specialist co-payment** **$10**
- **Hospital (facility) co-insurance** **10%**
- **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 | $450 |
| Co-payments | $400 |
| Co-insurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,070** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$450**
- **Specialist co-payment** **$10**
- **Hospital (facility) co-insurance** **10%**
- **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 | $450 |
| Co-payments | $40 |
| Co-insurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$790** |

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