



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?	\$6,000 person / \$12,000 family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, the <u>deductible</u> doesn't apply to <u>preventive care</u> or pediatric vision services.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$8,900 person / \$17,800 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, services that exceed an annual day/visit limit, and any <u>co-pays</u> and <u>co-insurance</u> you pay for any non-essential health benefits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. You will receive care within the Southeast MI Network of doctors and hospitals located around Oakland, Macomb and Wayne counties. See PriorityHealth.com or call 1-800-528-8762 for a list of <u>participating providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do I need a referral to see a specialist?	No.	You can see an in-network <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 co-pay/ visit	Not covered	Deductible does not apply to services subject to office visits or limited virtual care services.
	Specialist visit	\$80 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. 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)	40% co-insurance	Not covered	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	40% 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 More information about prescription drug coverage is available at https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi	Preferred generic drugs (Tier 1a)	\$20 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. 40% co-insurance/ prescription for infertility drugs. Deductible does not apply to generic and preferred brand drugs only.
	Other generic drugs (Tier 1b)	\$20 co-pay/ retail prescription	Not covered	
	Preferred brand drugs (Tier 2)	\$40 co-pay/ retail prescription	Not covered	
	Non-Preferred brand drugs (Tier 3)	\$80 co-pay/ retail prescription	Not covered	
	Preferred specialty drugs (Tier 4)	\$350 co-pay/ retail prescription	Not covered	-----none-----
	Non-Preferred specialty drugs (Tier 5)	\$350 co-pay/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% co-insurance/ visit	Not covered	Including outpatient care, observation care and ambulatory surgery center care. Prior authorization may be required.
	Physician/surgeon fees	40% co-insurance/ visit	Not covered	
If you need immediate medical attention	Emergency room services	40% co-insurance/ visit	40% co-insurance/ visit	-----none-----
	Emergency medical transportation	40% co-insurance	40% co-insurance	-----none-----
	Urgent care	\$60 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)	40% co-insurance/ visit	Not covered	Prior authorization is required, except in emergencies.
	Physician/surgeon fee	40% co-insurance/ visit	Not covered	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$40 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	40% co-insurance/ visit	Not covered	Prior authorization is required, except in emergencies.
	Substance use disorder outpatient services	\$40 co-pay/ visit	Not covered	Deductible does not apply.
	Substance use disorder inpatient services	40% 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. Appropriate office visit charge may apply to physician office services for complications of pregnancy.
	Delivery professional fees	40% co-insurance/ visit	Not covered	-----none-----
	Delivery facility fees	40% co-insurance/ 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 need help recovering or have other special health needs	Home health care	40% co-insurance/ visit	Not covered	Including hospice care services; excluding rehabilitation and habilitation services. Prior authorization required, except for hospice care services.
	Rehabilitation services	\$40 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. Deductible does not apply.
	Habilitation services for treatment of Autism Spectrum Disorder <i>only</i>	\$40 co-pay/ visit	Not covered	Prior authorization required for Applied Behavior Analysis (ABA). Covered services include Physical, Occupational, and Speech Therapy and Applied Behavior Analysis (ABA). Multiple charges may apply during one day of service. Deductible does not apply.
	Habilitation services not for the treatment of Autism Spectrum Disorder	\$40 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. Deductible does not apply.
	Skilled nursing care	40% co-insurance/ visit	Not covered	Services limited to a combined 45 days per contract year. Prior authorization required, except for hospice care services.
	Durable medical equipment (DME)	40% co-insurance/ visit	Not covered	Including rental, purchase or repair. Prior authorization required for equipment over \$1,000 and all rentals.
	Hospice service	40% 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. 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.)

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| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care (Adult & Child) | • Non-emergency care when traveling outside the U.S. | • Routine foot care |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)

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| • Bariatric surgery | • Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility | • Routine eye care (Child) |
| • Chiropractic care | | • 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, kwijigo holne' 1-800-528-8762.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section-----

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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 <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Specialist co-payment</u>	\$80
■ Hospital (facility) <u>co-insurance</u>	40%
■ Other <u>co-insurance</u>	40%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,000
Co-payments	\$10
Co-insurance	\$2,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$8,670

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Specialist co-payment</u>	\$80
■ Hospital (facility) <u>co-insurance</u>	40%
■ Other <u>co-insurance</u>	40%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$900
Co-payments	\$1,100
Co-insurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Specialist co-payment</u>	\$80
■ Hospital (facility) <u>co-insurance</u>	40%
■ Other <u>co-insurance</u>	40%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,100
Co-payments	\$400
Co-insurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,500

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