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 1-800-446-5674. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-446-5674 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$125 individual / $250 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 individual 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, certain services subject to flat dollar copays and prescription drugs.	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?	$2,000 individual / $4,000 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 billing, charges health care this plan doesn't cover, services that exceed an annual day/visit limit, and any copays and coinsurance you pay for any non-essential health benefit.	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 1-800-446-5674 for a list of network 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 you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All **copayment** and **coinsurance** 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
		Network Provider (You will pay the least)	Out-of-Network 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 copay visit Deductible does not apply.	Not covered	Prescription drug copay may also apply when selected injectable drugs are provided. Prescription drugs for infertility treatment covered only with prescription drug addendum. Retail health clinic services are covered at reasonable and customary charges.
	Specialist visit	$20 copay visit Deductible does not apply.	Not covered	
	Preventive care/screening/ immunization	No charge Deductible does not apply.	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)	No charge	Not covered	Prior Approval required for genetic testing. Deductible does not apply to laboratory services.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior Approval required for certain radiology examinations.
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.	Generic drugs	$10 copay (retail) $20 copay (mail order) Deductible does not apply.	Not covered	Costs shown in the "Your Cost" columns apply to drugs on the approved drug list when obtained from a participating provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription). Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable copayments at a retail participating pharmacy. 50% coinsurance / prescription for infertility drugs.
	Preferred brand drugs	$30 copay (retail) $60 copay (mail order) Deductible does not apply.	Not covered	
	Non-preferred brand drugs	$60 copay (retail) $120 copay (mail order) Deductible does not apply.	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.PriorityHealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Including outpatient care, observation care and ambulatory surgery center care. Prior approval may be required. Prior approval is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$200 copay/ visit Deductible does not apply.	$200 copay/ visit Deductible does not apply.	Copay waived if you are admitted as inpatient.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$20 copay/ visit Deductible does not apply.	$20 copay/ visit Deductible does not apply.	Urgent Care services received from a non-participating provider who is located in our service area are not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Prior approval is required at least 5 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 must be provided for all admissions following emergency room care. Prior approval is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not covered, even if the first procedure occurred prior to joining this plan. Unlimited days.
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ visit Deductible does not apply.	Not covered	No charge for first three behavioral health visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. Prior Approval required for intensive outpatient substance abuse treatment. Including medication management visits.
	Inpatient services	No charge	Not covered	Including Residential Treatment and partial hospitalization for behavioral health. Including subacute Residential Treatment and partial hospitalization for substance use disorder. Except in an emergency, prior approval required.
If you are pregnant	Office visits	No charge Deductible does not apply.	Not covered	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply to physician office services for complications of pregnancy. Cost Sharing does not apply for preventive services. Depending on the type of services, a copay or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). Postnatal and non-routine prenatal office visits-$20 copay. Only the routine prenatal visit is exempt from the deductible. Other services, deductible applies.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$20 copay/ visit	Not covered	Including hospice care services; excluding rehabilitation and habilitation services. Prior approval required except for hospice care services in the home.
	Rehabilitation services	$20 copay/ visit Deductible does not apply.	Not covered	Chiropractic manipulation limited to 30 visits per contract year. Physical, occupational, and speech therapy limited to a combined 90 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits per calendar year.
	Habilitation services	$20 copay/ visit	Not covered	No charge for Applied Behavior Analysis (ABA) services. Prior Approval required for Applied Behavior Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service.
	Skilled nursing care	No charge	Not covered	Services received in a skilled nursing care facility, subacute facility, or inpatient rehabilitation care facility are limited to a combined 120 days per confinement. Prior approval required.
	Durable medical equipment	No charge Deductible does not apply.	Not covered	Including rental, purchase or repair. Prior Approval required for equipment over $1,000, all rentals and all shoe inserts.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing
- 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; 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; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-800-446-5674 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 the Minimum Value Standards? **Yes**

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 1-800-446-5674.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-446-5674.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-446-5674.

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, copayments and coinsurance) and excluded services under the 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	**$125**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**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	$125
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$145**

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

The plan's overall deductible	**$125**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**0%**

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	$125
Copayments	$720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$900**

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

The plan's overall deductible	**$125**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**0%**

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	$125
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$475**

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