




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 <a href="#">deductible</a> ?	\$0 individual / \$0 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, the <a href="#">deductible</a> doesn't apply to <a href="#">preventive care</a> , certain services subject to flat dollar <a href="#">copays</a> and <a href="#">prescription drugs</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,000 individual / \$4,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> , charges health care this <a href="#">plan</a> doesn't cover, services that exceed an annual day/visit limit, and any <a href="#">copays</a> and <a href="#">coinsurance</a> you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See PriorityHealth.com or call 1-800-446-5674 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> visit <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Prescription drug copay</a> may also apply when selected injectable drugs are provided. <a href="#">Prescription drugs</a> for infertility treatment covered only with prescription drug addendum. Retail health clinic services are covered at reasonable and customary charges.  <a href="#">Preventive care</a> 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 <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	Not covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Prior Approval required for genetic testing. <a href="#">Deductible</a> does not apply to laboratory services.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior Approval required for certain radiology examinations.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi">https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi</a>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> / retail prescription \$20 <a href="#">copay</a> / mail order prescription <a href="#">Deductible</a> 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 <a href="#">provider</a> . 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 ( <a href="#">excluding Specialty Drugs</a> ) may be obtained at one time for three applicable <a href="#">copayments</a> at a retail participating pharmacy. 50% <a href="#">coinsurance</a> / prescription for infertility drugs.
	Preferred brand drugs (Tier 2)	\$30 co-pay/ retail prescription \$60 co-pay/ mail order prescription <a href="#">Deductible</a> does not apply.	Not covered	
	Non-preferred brand drugs (Tier 3)	\$60 co-pay/ retail prescription \$120 co-pay/ mail order prescription <a href="#">Deductible</a> does not apply.	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 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 <a href="#">medically necessary</a> , 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	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	\$200 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	<a href="#">Copay</a> waived if you are admitted as inpatient.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	\$20 <a href="#">copay</a> / visit <a href="#">Deductible</a> 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 <a href="#">emergency room care</a> . Prior approval is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless <a href="#">medically necessary</a> , 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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">copay</a> / visit <a href="#">Deductible</a> 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.
<b>If you are pregnant</b>	Office visits	No charge <a href="#">Deductible</a> 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 <a href="#">specialist</a> ) may apply to physician office services for complications of pregnancy. <a href="#">Cost Sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> or <a href="#">deductible</a> 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 <a href="#">copay</a> . Only the routine prenatal visit is exempt from the <a href="#">deductible</a> . Other services, <a href="#">deductible</a> applies.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$20 <a href="#">copay</a> / visit	Not covered	Including hospice care services; excluding <a href="#">rehabilitation</a> and habilitation services. Prior approval required except for hospice care services in the home.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> / visit	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 <a href="#">rehabilitation</a> & pulmonary <a href="#">rehabilitation</a> limited to a combined 30 visits per calendar year.
	<a href="#">Habilitation services</a>	•\$20 <a href="#">copay</a> / 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.
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Services received in a <a href="#">skilled nursing care</a> facility, subacute facility, or inpatient <a href="#">rehabilitation</a> care facility are limited to a combined 120 days per confinement. Prior approval required.
	<a href="#">Durable medical equipment</a>	No charge <a href="#">Deductible</a> does not apply.	Not covered	Including rental, purchase or repair. Prior Approval required for equipment over \$1,000, all rentals and all shoe inserts.
	<a href="#">Hospice services</a>	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 documents for more information and a list of any other [excluded services](#).)

- |                       |  |                            |
|-----------------------|--|----------------------------|
| • Acupuncture         | • Long-term care                                     | • Routine eye care (Adult) |
| • Cosmetic surgery    | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Dental care (Adult) |  |                            |

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

- |                     |                         |                        |
|---------------------|-------------------------|------------------------|
| • Bariatric surgery | • Hearing aids          | • Private-duty nursing |
| • Chiropractic care | • Infertility treatment | • 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](mailto: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](http://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](http://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](http://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](http://www.priorityhealth.com); the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto: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](mailto:difs-HICAP@michigan.gov).

## Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## 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, kwijigo 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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or <a href="#">exclusions</a>	\$60
<b>The total Peg would pay is</b>	<b>\$120</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$72
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or <a href="#">exclusions</a>	\$55
<b>The total Joe would pay is</b>	<b>\$127</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$350
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or <a href="#">exclusions</a>	\$0
<b>The total Mia would pay is</b>	<b>\$475</b>