### Important Questions | Answers | Why this Matters
--- | --- | ---
**What is the overall deductible?** | For participating providers $1,000 person / $2,000 family For non-participating providers $1,500 person / $3,000 family The deductible for each benefit level is calculated separately. Amounts you pay toward the deductible do not count toward any co-insurance maximums. | 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 preferred benefits deductible doesn’t apply to preventive care, certain services subject to flat dollar co-pays 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/](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?** | Yes. For participating providers $7,150 person / $14,300 family For non-participating providers $14,300 person / $28,600 family Your plan also has a co-insurance maximum. For participating providers $1,000 person / $2,000 family For non-participating providers $1,500 person / $3,000 family The co-insurance maximum limits the total amount of co-insurance you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the out-of-pocket limit. The out-of-pocket limit and co-insurance maximum for each benefit level is calculated separately. | 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 benefit. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
**Does this plan use a participating of providers?** | Yes. See PriorityHealth.com or call 1-800-446-5674 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 don’t need a referral in order to receive the preferred benefit for services provided by a participating specialist. Yes, you do need a referral in order to receive the preferred benefit for services provided by a non-participating specialist. | You can see the in-participating specialist you choose without a referral. This plan will pay some or all of the costs to see an out-of-network specialist for covered services but only if you have a referral before you see the specialist. |
All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 co-pay/visit</td>
<td>30% co-insurance/visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35 co-pay/visit</td>
<td>30% co-insurance/visit</td>
</tr>
</tbody>
</table>
|                                                           | Other practitioner office visit                                                       | • $50 co-pay/visit for evaluation/management services only at retail health clinics  | • Evaluation/management services only at retail health clinics covered at the preferred benefit level  
• 50% co-insurance/visit for family planning/infertility services  
• 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery                                                                                                                                                     |
|                                                           | Preventive care/screening/immunization                                                | No charge                                                                        | 30% co-insurance/visit  
Preventive care services are those listed in Priority Health’s Preventive Health Care Guidelines, including women’s preventive health care services. Preferred benefit level 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)                                                    | 10% co-insurance                                                                  | 30% co-insurance                                                                                                                                                                                                                                            |
|                                                           | Imaging (CT/PET scans, MRIs)                                                         | $150 co-pay                                                                       | 30% co-insurance  
Prior Approval required for certain radiology examinations. Preferred benefits co-pay waived if performed while confined in a hospital as an inpatient. Maximum of 10 co-pays per individual per contract year for imaging services. Preferred benefit level deductible does not apply. |

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.
<table>
<thead>
<tr>
<th>Common Medical Events</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td>Costs shown in the &quot;Your Cost&quot; 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% co-insurance/ prescription for infertility drugs. Deductible does not apply.</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$10 co-pay/ retail prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$20 co-pay/ retail prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$20 co-pay/ retail prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Preferred specialty drugs</td>
<td>$20 co-pay/ retail prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Non-preferred specialty drugs</td>
<td>$20 co-pay/ retail prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% co-insurance/ visit</td>
<td>30% co-insurance/ visit</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% co-insurance/ visit</td>
<td>30% co-insurance/ visit</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td>Co-pay waived if you become confined in a Hospital as an inpatient. Preferred benefit level deductible does not apply.</td>
</tr>
<tr>
<td>Emergency room services</td>
<td>$100 co-pay/ visit</td>
<td>Covered at the preferred benefit level</td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>$50 co-pay</td>
<td>Covered at the preferred benefit level</td>
<td>Preferred benefit level deductible does not apply.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 co-pay/ visit</td>
<td>30% co-insurance/ visit</td>
<td>Urgent Care services received from a Non-Participating Provider who is located outside of our Service Area are Covered at the Preferred Benefit level. Preferred benefit level deductible does not apply.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Events</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>Participating Provider (You will pay the least): 10% co-insurance/visit</td>
<td>Non-Participating Provider (You will pay the most): 30% co-insurance/visit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% co-insurance/visit</td>
<td>30% co-insurance/visit</td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$20 co-pay/visit</td>
<td>30% co-insurance/visit</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% co-insurance/visit</td>
<td>30% co-insurance/visit</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$20 co-pay/visit</td>
<td>30% co-insurance/visit</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% co-insurance/visit</td>
<td>30% co-insurance/visit</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Routine prenatal and postnatal care</td>
<td>No charge</td>
<td>30% co-insurance/visit</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>10% co-insurance/visit</td>
<td>30% co-insurance/visit</td>
</tr>
<tr>
<td>Common Medical Events</td>
<td>Services You May Need</td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>No charge</td>
<td>30% co-insurance/ visit</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services <em>not for the treatment of Autism Spectrum Disorder</em></td>
<td>$20 co-pay/ visit</td>
<td>50% co-insurance/ visit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services for treatment of Autism Spectrum Disorder <em>only</em></td>
<td>•$20 co-pay/ visit for Physical, Occupational and Speech Therapy •10% co-insurance/ visit for Applied Behavior Analysis (ABA) services</td>
<td>50% co-insurance/ visit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services not for the treatment of Autism Spectrum Disorder</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% co-insurance/ visit</td>
<td>30% co-insurance/ visit</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (DME)</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Prosthetics &amp; orthotics</td>
<td>10% co-insurance</td>
<td>50% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No charge</td>
<td>30% co-insurance/ visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Child eye exam</th>
<th>Not covered</th>
<th>Not covered</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Child dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.
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                                   | • Habilitation services not for the treatment of Autism Spectrum Disorder | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery                              | • Hearing aids                                   | • Private-duty nursing                            |
| • Dental care (Adult & Child)                   | • Long-term care                                 | • Routine eye care (Adult & Child)                |
|                                                  |                                                  | • Routine foot care                               |

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

<table>
<thead>
<tr>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Emergency services provided outside the U.S.</td>
</tr>
<tr>
<td>• Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

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 x6156 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. 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 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, 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-participating pre-natal care and a hospital delivery)

- The plan’s overall deductible: $1,000
- Specialist co-payment: $50
- 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**: $12,800

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$130</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$2,480</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60
- The total Peg would pay is: $3,670

---

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

- The plan’s overall deductible: $1,000
- Specialist co-payment: $50
- Hospital (facility) co-insurance: 10%
- Other co-insurance: 10%

**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**: $7,400

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$971</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$1,495</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$891</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $55
- The total Joe would pay is: $3,412

---

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

- The plan’s overall deductible: $1,000
- Specialist co-payment: $50
- Hospital (facility) co-insurance: 10%
- Other co-insurance: 10%

**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**: $1,900

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$518</td>
</tr>
<tr>
<td>Co-payments</td>
<td>$440</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$143</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0
- The total Mia would pay is: $1,101

---

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