Benefits summary:

PriorityHMO 250 90% - Platinum

PriorityHealth

Beginning on or after 01.01.2017

This document is intended to be an easy-to-read summary to provide a general overview of your benefits. It is not a contract or legal document. Additional limitations and exclusions may apply to covered services. This plan has a specific network of providers, so check the Provider Directory prior to receiving services. Prior authorizations for certain services may apply. A complete description of benefits is contained in the Certificate of Coverage, Schedule or Agreement as applicable.

Member cost-sharing	
Deductible *The amount you pay before we begin to pay.*	$250 individual/$500 family Deductible costs don't apply towards your coinsurance maximum
Coinsurance *Your share of the costs of a covered health care service.*	10% coinsurance for in-network services after deductible is met, except where noted.
Coinsurance maximum *The most coinsurance cost share you'll pay for covered services in a contract year. Your coinsurance cost share counts toward your out-of-pocket maximum.*	$1500 individual/$3,000 family
Out-of-pocket maximum *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$5,000 individual/$10,000 family
Office visits	
Primary care provider (PCP)	$10 copayment, deductible doesn't apply
Specialists	$25 copayment, deductible doesn't apply
Urgent care	$75 copayment, deductible doesn't apply
Virtual visits *24/7 care for non-emergency conditions*	$10 copayment, deductible doesn't apply
Allergy testing, serum and injections	Covered in full
Retail health clinic *Located in a retail center, like a supermarket or pharmacy and provides care for common illnesses and services (examples: ear aches, sore throats, flu shots)*	$75 copayment, deductible doesn't apply
Mental and behavioral health	
Inpatient hospital	10% coinsurance after deductible
Outpatient office visits	$10 copayment, deductible doesn't apply
Prescription drug coverage *Visit **priorityhealth.com** and search **Approved Drug** list to see a list of covered drugs and pricing information.*	
Generic	$10 copayment (deductible doesn't apply)

Brand	$40 preferred brand copayment / $80 non-preferred brand copayment (deductible doesn't apply)
Specialty	20% coinsurance up to a maximum copayment of $100 per preferred brand fill and $200 per non-preferred brand fill (deductible doesn't apply)
Preventive care	
Preventive care, immunizations	Covered in full; includes women's preventative health care services, well-child visits, flu shots and routine physical exams. Get the most up-to-date list of all the care that's recommended in our Preventative Health Care Guidelines when you login to your online account at priorityhealth.com
Laboratory and X-ray	
Radiology	10% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	$150 copayment after deductible
Laboratory	10% coinsurance after deductible
Emergency Services	
Emergency room	$150 copayment after deductible
Emergency transportation/ ambulance services	$150 copayment after deductible
Hospital care	
Inpatient hospital physician services	10% coinsurance after deductible
Surgery and/or facility fee	10% coinsurance after deductible; exceptions apply
Bariatric surgery	50% coinsurance after deductible; covered once per lifetime
Outpatient Care	
Skilled nursing or critical services	10% coinsurance after deductible; combined maximum 45 visits per member each contract year
Outpatient surgery	10% coinsurance after deductible
In-home and hospice care	Covered in full
Rehabilitation services and devices	
Physical and occupational therapy (including chiropractic)	$10 copayment, deductible doesn't apply; combined maximum 30 visits per member per contract year
Speech therapy	$10 copayment, deductible doesn't apply; 30 visits per member per contract year
Prosthetic and orthotic support	50% coinsurance after deductible
Durable medical equipment (DME)	50% coinsurance after deductible
Family planning and maternity care	
Family planning	50% coinsurance after deductible
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services.
Maternity delivery and nursery care	10% coinsurance after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient care facility charges are subject to deductible and coinsurance when in connection with delivery or other covered inpatient surgery
Vasectomy	Covered in full when performed in physician's office

Additional Benefits

Cost estimator: Calculates specific costs for hundreds of procedures, based on where you're at with

your deductible, coinsurance, etc. If a selected procedure is above fair market price, the tool will provide a list of nearby facilities where it's offered at a lower cost.

Travel assistance: If you become ill or injured while traveling more than 100 miles from home, AssistAmerica® coverage is included in your plan. Receive help with medical care, coordinating prescriptions, assistance with lost luggage, and even arrange your travel back home.

Member perks: Earn up to 20% cash back when you purchase digital gift cards from hundreds of local and national retailers — from Amazon to Zappos. Redeem online or at checkout at the store.

Benefits summary:

PriorityHSA 1350 2-tier Rx - Gold

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Member cost-sharing	
Deductible *The amount you pay before we begin to pay.*	$1,350 individual/$2,700 family Deductible costs don't apply towards your coinsurance maximum
Coinsurance *Your share of the costs of a covered health care service.*	10% coinsurance for in-network services after deductible is met, except where noted.
Coinsurance maximum *The most coinsurance cost share you'll pay for covered services in a contract year. Your coinsurance cost share counts toward your out-of-pocket maximum.*	$0 individual/$ family
Out-of-pocket maximum *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$2,400 individual/$4,800 family
Office visits	
Primary care provider (PCP)	10% coinsurance after deductible
Specialists	10% coinsurance after deductible
Urgent care	10% coinsurance after deductible
Virtual visits *24/7 care for non-emergency conditions*	10% coinsurance after deductible
Allergy testing, serum and injections	after deductible
Retail health clinic *Located in a retail center, like a supermarket or pharmacy and provides care for common illnesses and services (examples: ear aches, sore throats, flu shots)*	10% coinsurance after deductible
Mental and behavioral health	
Inpatient hospital	10% coinsurance after deductible
Outpatient office visits	10% coinsurance after deductible
Prescription drug coverage *Visit **priorityhealth.com** and search **Approved Drug** list to see a list of covered drugs and pricing information.*	
Generic	$10 copayment, after deductible

Brand	$40 preferred brand copayment / $80 non-preferred brand copayment, after deductible
Specialty	20% coinsurance, after deductible
Preventive care	
Preventive care, immunizations	Covered in full; includes women's preventative health care services, well-child visits, flu shots and routine physical exams. Get the most up-to-date list of all the care that's recommended in our Preventative Health Care Guidelines when you login to your online account at priorityhealth.com
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Advanced imaging (CT/ PET/MRI)	10% coinsurance after deductible
Laboratory	10% coinsurance after deductible
Emergency Services	
Emergency room	10% coinsurance after deductible
Emergency transportation/ ambulance services	10% coinsurance after deductible
Hospital care	
Inpatient hospital physician services	10% coinsurance after deductible
Surgery and/or facility fee	10% coinsurance after deductible; exceptions apply
Bariatric surgery	50% coinsurance after deductible; covered once per lifetime
Outpatient Care	
Skilled nursing or critical services	10% coinsurance after deductible; combined maximum 45 visits per member each contract year
Outpatient surgery	10% coinsurance after deductible
In-home and hospice care	10% coinsurance after deductible
Rehabilitation services and devices	
Physical and occupational therapy (including chiropractic)	10% coinsurance after deductible; combined maximum 30 visits per member per contract year
Speech therapy	10% coinsurance after deductible; combined maximum 30 visits per member per contract year
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Family planning and maternity care	
Family planning	50% coinsurance after deductible
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services.
Maternity delivery and nursery care	10% coinsurance after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient care facility charges are subject to deductible and coinsurance when in connection with delivery or other covered inpatient surgery after deductible
Vasectomy	10% coinsurance after deductible

Additional Benefits

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