Summary of benefits

MyPriority PPO

	80% Medical 60% Brand/Generic Drug						70% Medical 60% Brand/GenericDrug		70% Medical 50% Generic Drugs Only	
Annual deductible in-network[1] – single	**$1,000**	**$2,500**	**$3,500**	**$5,000**	**$7,500**	**$10,000**	**$1,000**	**$2,500**	**$1,000**	**$3,000**
– family	**$2,000**	**$5,000**	**$7,000**	**$10,000**	**$15,000**	**$20,000**	**$2,000**	**$5,000**	**$2,000**	**$6,000**
Annual deductible out-of-network – single	**$2,000**	**$5,000**	**$7,000**	**$10,000**	**$15,000**	**$20,000**	**$2,000**	**$5,000**	**$2,000**	**$6,000**
– family	**$4,000**	**$10,000**	**$14,000**	**$20,000**	**$30,000**	**$40,000**	**$4,000**	**$10,000**	**$4,000**	**$12,000**
Coinsurance – Plan Pays: (unless otherwise noted)	• 80% in-network • 60% out-of-network						• 70% in-network • 50% out-of-network		• 70% in-network • 50% out-of-network	
Annual in-network out-of-pocket maximum[2] – single	$3,000	$4,500	$5,500	$7,000	$9,500	$12,000	$4,000	$6,500	$3,000	$9,000
– family	$6,000	$9,000	$11,000	$14,000	$19,000	$24,000	$8,000	$13,000	$6,000	$18,000
Annual out-of-network out-of-pocket maximum[2] – single	$10,000	$13,000	$15,000	$18,000	$23,000	$28,000	$12,000	$15,000	$12,000	$16,000
– family	$20,000	$26,000	$30,000	$36,000	$46,000	$56,000	$24,000	$30,000	$24,000	$32,000
Annual benefit maximum (for in and out-of-network services combined)	$2 million						$2 million		$2 million	

Benefit	What you pay		
Preventive care[3]	• $0; 100% covered	• $0; 100% covered	• $0; 100% covered
Doctor's office visits[4]	• $30 copay before deductible	• $30 copay before deductible	• $30 copay before deductible
Urgent care[4]			
Emergency room[5]	• $150 copay • 30% coinsurance in-network after deductible • 30% coinsurance out-of-network after deductible	• $150 copay • 30% coinsurance in-network after deductible • 30% coinsurance out-of-network after deductible	• $150 copay • 40% in-network coinsurance after deductible • 40% out-of-network coinsurance after deductible
Ambulance	• 30% coinsurance in-network after deductible • 30% coinsurance out-of-network after deductible	• 30% coinsurance in-network after deductible • 30% coinsurance out-of-network after deductible	• 40% in-network coinsurance after deductible • 40% out-of-network coinsurance after deductible
Outpatient lab/X-ray	• 20% coinsurance in-network after deductible • 40% coinsurance out-of-network after deductible	• 30% coinsurance in-network after deductible • 50% coinsurance out-of-network after deductible	• 30% coinsurance in-network after deductible • 50% coinsurance out-of-network after deductible
Outpatient surgery			
Hospitalization			
Outpatient speech therapy[6]			
Outpatient occupational therapy[6]			
Outpatient physical therapy/ spinal manipulation[6]			
Cardiac rehab[6]			
Skilled nursing; Subacute; Inpatient rehab; Hospice[7]			
Home health care[8]			
Substance abuse[9]			
Dietitian services[10]			

DME; P&O[11]	• 50% coinsurance after deductible	• 50% coinsurance after deductible	• 50% coinsurance after deductible
Prescription drug coverage[12]	• 40% copay for generics and brand drugs before deductible • Includes oral contraceptives.	• 40% copay for generics and brand drugs before deductible • Includes oral contraceptives.	• Generic drugs covered at 50% before deductible • Includes oral contraceptives • Brands at Priority Health discounted price before deductible
Medical specialty drugs[13]	• 20% coinsurance in-network after deductible • 40% coinsurance out-of network after deductible	• 30% coinsurance in-network after deductible • 50% coinsurance out-of-network after deductible	• 50% coinsurance after deductible
Transplants[14]	• At designated transplant facility	• At designated transplant facility	• At designated transplant facility

Optional Coverage			
Accident rider[15]	• 20% coinsurance in-network before deductible • 40% coinsurance out-of-network before deductible	• 30% coinsurance in-network before deductible • 50% coinsurance out-of-network before deductible	• 30% coinsurance in-network before deductible • 50% coinsurance out-of-network before deductible

Not covered (for all deductible options)

- Certain surgeries — bariatric surgery, blepharoplasty of upper eyelids, breast reduction, panniculectomy, surgical treatment of male gynecomastia and procedures to correct obstructive sleep apnea.
- Family planning/infertility services — vasectomy, tubal litigation, diaphragm, infertility counseling and treatment of underlying cause of infertility
- TMJ, port wine stains, orthognathic surgery

90-day waiting period (for all deductible options)

Surgeries subject to the 90 day waiting period include: Tonsillectomy, Adenoidectomy, Hemorrhoidectomy, Hysterectomy and Bunionectomy, Surgical treatment of the following conditions are also subject to the 90 day waiting period: Cystocele, Enterocele, Rectocele, Urethrocele, Uterine Prolapse, Inguinal Hernia (other than strangulated or incarcerated), Carpal Tunnel Syndrome and Varicose Veins.

Pre-existing condition exclusion	Benefits will be excluded for each Illness or Injury or condition not disclosed on the application, for which, during the six month period prior to the effective date, medical advice, diagnosis, care or treatment recommended by or received from a Health Professional. For purposes of this limitation, "treatment" includes the use of prescription drugs. This Pre-Existing Condition exclusion will apply until the end of the twelve month period beginning on the effective date under the policy. The Pre-Existing Condition exclusion does not apply to a newborn who becomes a Covered Dependent under this Policy within 31 days after the birth.

**For complete plan details go to priorityhealth.com*

1 *Family deductible may be met collectively by 2 or more individuals in the family*
2 *Excludes copays, includes coinsurance and deductible*
3 *Within Priority Health Preventive Health Care Guidelines*
4 *4 combined visits per member annually – after the 4 visits, covered charges apply towards deductible and coinsurance.*
5 *Copay waived if admitted within 24 hours*
6 *$3,000 combined annual max per member*
7 *60-day combined annual max per member*
8 *60 visits annual max per member*
9 *Up to the state-mandated benefit*
10 *6 visits per member per year*
11 *$2,000 max per member each year for in-network services; $2,000 max per member each year for out-of-network services*
12 *These expenses do not go towards your deductible or out-of-pocket maximum.*
13 *$25,000 maximum per member each year for services received out-of-network*
14 *$1,000,000 maximum*
15 *For services incurred within 60-days of the injury. After the 60-days the deductible will be applied to any covered charges.*