Benefits summary:

PriorityPOS 2000 - Gold

PriorityHealth

Beginning on or after 01.01.2020

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	In-Network	Out-of-Network
Deductible *The amount you pay before we begin to pay.*	$2,000 individual/$4,000 family embedded	$4,000 individual/$8,000 family embedded
Coinsurance *Your share of the costs of a covered health care service.*	20% coinsurance for in-network services after deductible is met, except where noted.	40% coinsurance of R&C (reasonable and customary) for out-of-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.*	$4,500 individual/$9,000 family embedded	$9,000 individual/$18,000 family embedded
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.*	$7,350 individual/$14,700 family embedded	$14,700 individual/$29,400 family embedded
Office visits	**In-Network**	**Out-of-Network**
Primary care provider (PCP)	$20 copayment, deductible doesn't apply	40% coinsurance of R&C after deductible
Specialists	$50 copayment, deductible doesn't apply	40% coinsurance of R&C after deductible
Urgent care	$75 copayment, deductible doesn't apply	40% coinsurance of R&C after deductible
Virtual visits *24/7 care for non-emergency conditions*	Covered in full, deductible doesn't apply	40% coinsurance of R&C after deductible
Allergy testing, serum and injections	Covered in full, deductible doesn't apply	40% coinsurance of R&C 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)*	$75 copayment, deductible doesn't apply	$75 copayment, deductible doesn't apply
Mental and behavioral health	**In-Network**	**Out-of-Network**
Inpatient hospital	20% coinsurance after deductible	40% coinsurance of R&C after deductible

Outpatient office visits	$20 copayment, deductible doesn't apply	40% coinsurance of R&C after deductible
Prescription drug coverage *Visit **priorityhealth.com** and search **Approved Drug** list to see a list of covered drugs and pricing information.*		
Generic	$5 copayment for preferred and $20 non-preferred generics (deductible doesn't apply)	Not covered
Brand	$60 preferred brand copayment / $80 non-preferred brand copayment (deductible doesn't apply)	Not covered
Specialty	20% coinsurance up to a maximum copayment of $250 per fill for preferred and $450 per fill for non-preferred (deductible doesn't apply)	Not covered
Preventive care	**In-Network**	**Out-of-Network**
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	40% coinsurance of R&C after deductible
Laboratory and X-ray	**In-Network**	**Out-of-Network**
Radiology	$60 copayment; deductible doesn't apply	40% coinsurance of R&C after deductible
Advanced imaging (CT/ PET/MRI)	$150 copayment after deductible	40% coinsurance of R&C after deductible
Laboratory	$20 copayment; deductible doesn't apply	40% coinsurance of R&C after deductible
Emergency Services	**In-Network**	**Out-of-Network**
Emergency room	$250 copayment after deductible	Covered at in-network benefit
Emergency transportation/ ambulance services	$250 copayment after deductible	Covered at in-network benefit
Hospital care	**In-Network**	**Out-of-Network**
Inpatient hospital physician services	20% coinsurance after deductible; exceptions apply	40% coinsurance of R&C after deductible; exceptions apply
Surgery and/or facility fee	20% coinsurance after deductible; exceptions apply	40% coinsurance of R&C after deductible; exceptions apply
Bariatric surgery	50% coinsurance after deductible; covered once per lifetime	50% coinsurance after deductible; covered once per lifetime
Outpatient Care	**In-Network**	**Out-of-Network**
Skilled nursing or critical services	20% coinsurance after deductible; combined maximum 45 visits per member each contract year	40% coinsurance of R&C after deductible; combined maximum 45 visits per member per contract year
Outpatient surgery	20% coinsurance after deductible	40% coinsurance of R&C after deductible
In-home and hospice care	Covered in full, deductible doesn't apply	40% coinsurance of R&C after deductible
Rehabilitation services and devices	**In-Network**	**Out-of-Network**
Physical and occupational therapy (including chiropractic)	$50 copayment, deductible applies; combined maximum 30 visits per member per contract year. Deductible doesn't apply to chiropractic visits.	50% coinsurance of R&C after deductible; combined maximum 30 visits per member per contract year
Speech therapy	$50 copayment, deductible applies; 30 visits per member per contract year	50% coinsurance of R&C after deductible; 30 visits per member per contract year
Prosthetic and orthotic support	50% coinsurance after deductible	50% coinsurance of R&C after deductible
Durable medical equipment (DME)	50% coinsurance after deductible	50% coinsurance of R&C after deductible

Family planning and maternity care	In-Network	Out-of-Network
Family planning	50% coinsurance after deductible	Not covered
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services.	40% coinsurance of R&C after deductible
Maternity delivery and nursery care	20% coinsurance after deductible	40% coinsurance of R&C 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	40% coinsurance of R&C after deductible
Vasectomy	Covered in full when performed in physician's office	Not covered

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

PriorityVision℠ for small business plans

(excluding **Priority**HSA and **Priority**Extras plans)

Summary of benefits

PriorityHealth

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at *priorityhealth.com* or by calling 877.572.4001.

Vision care services	In-network member cost	Out-of-network reimbursement
Exam with dilation as necessary	$15 copayment	Up to $30

PriorityVision discounts	In-network member cost after discount	Out-of-network reimbursement
Complete pair eyeglasses purchase discounts: Frame, lenses and lens options must be purchased in same transaction to receive full discount		
Frames		
Any available frame at provider location	40% off retail price	NA
Standard plastic lenses		
Single vision	$50	NA
Bifocal	$70	NA
Trifocal	$105	NA
Standard progressive lens	$135	NA
Lens options		
UV treatment	$15	NA
Tint (solid and gradient)	$15	NA
Standard plastic scratch coating	$15	NA
Standard polycarbonate	$40	NA
Standard polycarbonate - kids under 19	$40	NA
Standard anti-reflective coating	$45	NA
Polarized	20% off retail price	NA
Other add-ons and services	20% off retail price	NA
Contact lenses (discount applies to materials only)		
Conventional	15% off retail price	NA
Disposable	NA	NA
Laser vision correction		
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% of promotional price	NA
Additional discounts		
Non-prescription sunglasses	20% off retail price	NA

Frequency		
Examination	Once every 12 months	NA
Lenses or contact lenses	Unlimited	NA
Frame	Unlimited	NA

continued >

Learn more

For a complete list of providers near you, use our online Find a Doctor directory on *priorityhealth.com* and choose “Vision” or call 800.446.5674. For Lasik providers, call 877 5LASER6.

Plan exclusions

The following eye care services are not part of your plan:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eyes or their supporting structures.
- Any eye exam or eyewear required by an employer as a condition of employment, including safety eyewear.
- Services provided as a result of any Workers’ Compensation law, or similar legislation, or required by any governmental agency or program.
- Non-prescription lenses and/or contact lenses.
- Non-prescription sunglasses.
- Getting two pair of glasses instead of bifocals.
- Services or materials provided by any other group benefit plan that provides eye care.
- Discounts may not be allowed for some brand name eye care materials in which the manufacturer imposes a no-discount practice.
- Services you receive after your plan ends, except for eye care materials that were ordered before your coverage ended. These eye care materials, and services related to your order, may be covered even if they’re delivered after your coverage ends. Eye care services related to your delivery order may also be covered if you receive them within 31 days of placing your delivery order.
- Replacement of lost or broken lenses, frames, glasses or contact lenses. Replacement won’t be covered if you’ve already used your allowed vision benefits for your plan period.