

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2021 - 06/30/2022

Berrien RESA :

PPO Plan A – \$500 Deductible 100 %

Coverage for: Subscriber/Dependent | **Plan Type:** PPO



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 1-800-956-1954. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-956-1954 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	For <u>network providers</u> \$500 person / \$1,000 family For <u>non-network providers</u> \$1,000 person / \$2,000 family The amounts calculated toward the non-network benefits deductibles apply to the network benefits deductibles. The network benefits deductibles also apply to the non-network benefits deductibles. Amounts you pay toward the <u>deductible</u> do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, the network benefits <u>deductible</u> doesn't apply to <u>preventive care</u> , services subject to flat dollar <u>co-pays</u> and prescription drugs. Emergency room services are subject to the <u>deductible</u> and a <u>co-pay</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Yes, medical benefits. For <u>network providers</u> \$3,000 person / \$6,000 family. For <u>non-network providers</u> \$N/A. Yes, prescription drugs. For <u>network providers</u> \$3,600 person/\$7,200 family. For <u>non-network providers</u> . N/A. Your plan also has a co-insurance maximum. For <u>network providers</u> \$0 person / \$0 family For <u>non-network providers</u> \$3,000 person / \$6,000 family The co-insurance maximum limits the total amount of <u>co-insurance</u> you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the <u>out-of-pocket limit</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, and services that exceed an annual day/visit limit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See PriorityHealth.com or call 1-800-956-1954 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All co-payment and co-insurance 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)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 co-pay/ visit	20% co-insurance/ visit	<p>Network benefit level deductible does not apply to certain services subject to flat dollar co-pays.</p> <p>Prescription drug co-pay may also apply when selected injectable drugs are provided.</p> <p>Fertility treatment is limited to a combined lifetime maximum of \$500.</p> <p>Non-surgical TMJ Treatment is limited to a combined lifetime maximum of \$1,000.</p> <p>\$30 co-pay/ visit for chiropractic services provided by a network or non-network provider. Covered up to a combined contract year maximum of 25 visits for manipulations and massage therapy.</p>
	Specialist visit	\$30 co-pay/ visit	20% co-insurance/ visit	
	Other practitioner office visit	<ul style="list-style-type: none"> •\$30 co-pay/ visit for family planning/ infertility services •\$30 co-pay/ visit for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery 	<ul style="list-style-type: none"> •20% co-insurance/ visit for family planning/ infertility services •20% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery 	
	Preventive care/screening/immunization	No charge	20% co-insurance/ visit	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance	Prior Certification required for genetic testing.
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance	Prior Certification required for certain radiology examinations.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi	Generic drugs (Tier 1)	\$20 co-pay/ retail prescription \$20 co-pay/ mail order prescription	Not covered	Costs shown apply to drugs on the approved drug list. Covers up to a 34-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription) Medications provided in Priority Health's Preventive Healthcare Guidelines, including certain women's prescribed contraceptive methods are covered at no charge. Deductible does not apply.
	Preferred brand drugs (Tier 2)	\$50 co-pay/ retail prescription \$50 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	\$100 co-pay/ retail prescription \$100 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs (Tier 4)	\$50 co-pay/ retail prescription	Not covered	Deductible does not apply.
	Non-Preferred specialty drugs (Tier 5)	\$100 co-pay/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% co-insurance/ visit	Including outpatient care, observation care and ambulatory surgery center care. Prior certification may be required. Prior certification is required for bariatric surgery.
	Physician/surgeon fees	No charge	20% co-insurance/ visit	
If you need immediate medical attention	Emergency room services	\$150 co-pay/ visit	Covered at the network benefit level; R&C limitations apply	Co-pay waived if you become confined in a Hospital as an inpatient.
	Emergency medical transportation	No charge	Covered at the network benefit level; R&C limitations apply	-----none-----
	Urgent care	\$30 co-pay/ visit	20% co-insurance/ visit	Co-pay applies to all urgent care visits. Network benefit level deductible does not apply.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% co-insurance/ visit	Prior certification 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 emergency room care. Prior certification is required for bariatric surgery.
	Physician/surgeon fee	No charge	20% co-insurance/ visit	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$30 co-pay/ visit	20% co-insurance/ visit	Including medication management visits. Network level deductible does not apply.
	Mental/Behavioral health inpatient services	No charge	20% co-insurance/ visit	Including Residential Treatment and partial hospitalization. Except in an emergency, Prior certification required.
	Substance use disorder outpatient services	\$30 co-pay/ visit	20% co-insurance/ visit	Including medication management visits. Network level deductible does not apply.
	Substance use disorder inpatient services	No charge	20% co-insurance/ visit	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, Prior Certification required.
If you are pregnant	Routine prenatal and postnatal care	No charge	20% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply to physician office services for complications of pregnancy. Dependent children obstetrical services are limited to routine prenatal care services only.
	Delivery and all inpatient services	No charge	20% co-insurance/ visit	Dependent children obstetrical services and expenses are not covered.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance/ visit	Including hospice care services; excluding rehabilitation and habilitation services. Home health care services covered up to a combined contract year maximum of 40 visits. Prior certification required, except for hospice care services in the home.
	Rehabilitation services <i>not</i> for the treatment of Autism Spectrum Disorder	No charge	20% co-insurance/ visit	Includes physical, speech, and occupational therapy, and cardiac and pulmonary rehabilitation.
	Habilitation services for treatment of Autism Spectrum Disorder <i>only</i>	No charge	20% co-insurance/ visit	Covered services include Physical, Occupational and Speech Therapy. Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered
	Skilled nursing care	No charge	20% co-insurance/ visit	Includes services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility. Prior certification required, except for hospice care.
	Durable medical equipment (DME)	No charge	20% co-insurance/ visit	Including rental, purchase or repair. Prior certification required for equipment over \$1,000, all rentals and all shoe inserts.
	Prosthetics & orthotics	No charge	20% co-insurance/ visit	
	Hospice service	No charge	20% co-insurance/ visit	This benefit applies to hospice services provided in the home only and is subject to the Home Health Care Limits above. Any hospice services provided in a facility will be subject to the appropriate facility benefit.
If your child needs dental or eye care	Child eye exam	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered
	Child dental check-up	Not covered	Not covered	Not covered

* 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
- Cosmetic surgery
- Dental care (Adult & Child)
- Habilitation services not for the treatment of Autism Spectrum Disorder
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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; 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; 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 1-800-956-1954 or www.priorityhealth.com; 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.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-800-956-1954.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-956-1954.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-956-1954.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-956-1954.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section-----

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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-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist co-payment</u>	\$30
■ Hospital (facility) <u>co-insurance</u>	0%
■ Other <u>co-insurance</u>	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Co-payments	\$10
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$570

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist co-payment</u>	\$30
■ Hospital (facility) <u>co-insurance</u>	0%
■ Other <u>co-insurance</u>	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Co-payments	\$700
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist co-payment</u>	\$30
■ Hospital (facility) <u>co-insurance</u>	0%
■ Other <u>co-insurance</u>	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Co-payments	\$200
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

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