Plan ID 721036

Benefits summary:

HMO $1000-80% Tiered Copay Plan

PriorityHealth

Coverage period: 01.01.2023 to 12.31.2023

Providing strong coverage for most commonly used benefits

PACE North

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 ma 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.*	$1,000 individual/$2,000 family Deductible costs don't apply towards your coinsurance maximum. Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	20% coinsurance for services after deductible is met, except where noted. Out-of-network services not covered.
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 limit.*	$4,000 individual/$8,000 family
Out-of-pocket limit *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$8,700 individual/$17,400 family
Office visits	
Primary care provider (PCP)	$15 copayment, deductible doesn't apply
Specialists	$30 copayment, deductible doesn't apply
Urgent care	$75 copayment, deductible doesn't apply
Virtual Care Services *24/7 care for non-emergency medical conditions*	Covered in full
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	20% coinsurance after deductible
Outpatient office visits	$15 copayment, deductible doesn't apply

Prescription drug coverage - Deductible doesn't apply *Visit priorityhealth.com and search Optimized or Traditional in the **Approved Drug** list to see coverage and pricing information.*	
Formulary	Traditional
Tier 1	$20 copayment
Tier 2	$60 copayment
Tier 3	$80 copayment
Tier 4	20% coinsurance, $200 max
Tier 5	20% coinsurance, $400 max
Mail Order	90 day supply via mail-order for Tier 1, Tier 2, and Tier 3 are 2x copayment
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	20% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	$250 copayment after deductible
Laboratory	20% coinsurance after deductible
Emergency services	
Emergency room	$250 copayment after deductible
Emergency transportation/ ambulance services	$250 copayment after deductible
Hospital care	
Inpatient hospital physician services	20% coinsurance after deductible
Surgery and/or facility fee	20% coinsurance after deductible; exceptions apply
Bariatric surgery	20% coinsurance after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	20% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	20% coinsurance after deductible
In-home and hospice care	Covered in full after deductible
Rehabilitation services and devices	
Physical and occupational therapy	$15 copayment, deductible doesn't apply Combined maximum 30 visits per member per contract year
Chiropractic care	$15 copayment, deductible doesn't apply Maximum 30 visits per member per contract year
Speech therapy	$15 copayment, deductible doesn't apply; Maximum 30 visits per member per contract year
Prosthetic and orthotic support	Covered in full after deductible
Durable medical equipment (DME)	Covered in full 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	20% coinsurance after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient 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 or in connection with other surgery

Riders	
Durable medical equipment	See above
Prosthetics and orthotics	See above

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 o 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.