

# Benefits summary:

## PriorityHSA HMO Gold G16



Beginning on or after 01.01.2024

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	
<b>Deductible</b> <i>The amount you pay before we begin to pay.</i>	\$1,600 individual / \$3,200 family aggregate
<b>Coinsurance</b> <i>Your share of the costs of a covered health care service.</i>	20% coinsurance for in-network services after deductible is met, except where noted.
<b>Coinsurance maximum</b> <i>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.</i>	N/A
<b>Out-of-pocket maximum</b> <i>The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.</i>	\$4,000 individual / \$8,000 family embedded
Routine Care	
<b>Primary care provider (PCP)</b>	Face-to-Face visits: 20% coinsurance after deductible Telehealth/virtual: \$10 copayment after deductible
<b>Specialists</b>	Face-to-Face visits: 20% coinsurance after deductible Telehealth/virtual: \$10 copayment after deductible
<b>Urgent care and retail health clinics</b>	20% coinsurance after deductible (retail health clinics: 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)
<b>Virtual care</b> <i>24/7 care for non-emergency conditions</i>	\$10 copayment after deductible
<b>Allergy testing, serum and injections</b>	20% coinsurance after deductible
<b>Diabetic services and supplies</b> <i>(Including education classes furnished by a Participating Provider; and select diabetes supplies when purchased by a Participating DME provider)</i>	100% coverage for education classes furnished; 100% coverage for blood glucose monitors, syringes, needles, lancets and blood glucose test strips, insulin pumps, shoe inserts for members with peripheral neuropathy, including diabetic neuropathy, special shoes prescribed for a person with diabetes when Medically/Clinically Necessary according to the criteria set form in our medical policies; deductible applies  Prior Authorization required for devices over \$1,000.00 and all shoe inserts
Mental and behavioral health	
<b>Inpatient hospital</b>	20% coinsurance after deductible
<b>Outpatient office visits</b>	Face-to-Face visits: 20% coinsurance after deductible Telehealth/virtual: \$10 copayment after deductible
Prescription drug coverage	
<i>Visit <a href="http://priorityhealth.com">priorityhealth.com</a> and search <b>Approved Drug</b> list to see a list of covered drugs and pricing information. Select optimized.</i>	
<b>Tier 1a / Tier 1b</b>	\$5 / \$35 copayment, after deductible; Mail order - 90-day supply for 2 copayments

<b>Tier 2 / Tier 3</b>	\$65 / \$85 copayment, after deductible; Mail order - 90-day supply for 2 copayments
<b>Tier 4 / Tier 5</b>	20% coinsurance up to a maximum copayment of \$250 per fill for preferred and \$450 per fill for non-preferred, after deductible
<b>Preventive care</b>	
<b>Preventive care, immunizations</b>	100% coverage; 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 <a href="http://priorityhealth.com">priorityhealth.com</a>
<b>Laboratory and X-ray</b>	
<b>Radiology</b>	20% coinsurance after deductible
<b>Advanced imaging (CT/PET/MRI)</b>	20% coinsurance after deductible
<b>Laboratory</b>	20% coinsurance after deductible
<b>Emergency Services</b>	
<b>Emergency room</b>	20% coinsurance after deductible
<b>Emergency transportation/ ambulance services</b>	20% coinsurance after deductible
<b>Hospital care</b>	
<b>Inpatient hospital physician services</b>	20% coinsurance; exceptions apply after deductible
<b>Surgery and/or facility fee</b>	20% coinsurance after deductible; exceptions apply
<b>Bariatric surgery</b>	50% coinsurance after deductible; covered once per lifetime
<b>Outpatient Care</b>	
<b>Skilled nursing or critical services</b>	20% coinsurance after deductible; combined maximum 45 visits per member each contract year
<b>Outpatient surgery</b>	20% coinsurance after deductible
<b>In-home and hospice care</b>	20% coinsurance after deductible
<b>Rehabilitation services and devices</b>	
<b>Physical and occupational therapy</b>	20% coinsurance after deductible; combined maximum 30 visits per member per contract year
<b>Chiropractic and osteopathic manipulations</b>	20% coinsurance after deductible; combined maximum 30 visits per member per contract year
<b>Speech therapy</b>	20% coinsurance after deductible; 30 visits per member per contract year
<b>Prosthetic and orthotic support</b>	50% coinsurance after deductible
<b>Durable medical equipment (DME)</b>	50% coinsurance after deductible
<b>Family planning and maternity care</b>	
<b>Family planning &amp; infertility</b>	50% coinsurance after deductible for treatment of the underlying cause
<b>Routine prenatal and postpartum care</b>	100% coverage for evaluation and management; see Preventative Health Care Guidelines for recommendations and services.
<b>Maternity delivery and nursery care</b>	20% coinsurance after deductible
<b>Tubal ligation</b>	100% coverage 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
<b>Vasectomy</b>	20% coinsurance when performed in physician's office or in connection with other surgery after deductible

## 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.

**TruHearing discount program:** Discounts on hearing exams and high quality hearing aides available to you and your extended family