Benefits summary:
PriorityHSA HMO Gold G16

Priority Health

Beginning on or after 01.01.2025

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	
Deductible *The amount you pay before we begin to pay.*	$1,650 individual / $3,300 family aggregate
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.
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.*	N/A
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.*	$4,500 individual / $9,000 family embedded
Routine Care	
Primary care provider (PCP)	Face-to-Face visits: 20% coinsurance after deductible Telehealth/virtual: $10 copayment after deductible
Specialists	Face-to-Face visits: 20% coinsurance after deductible Telehealth/virtual: $10 copayment after deductible
Urgent care and retail health clinics	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)
Virtual care *24/7 care for non-emergency conditions*	$10 copayment after deductible
Allergy testing, serum and injections	20% coinsurance after deductible
Diabetic services and supplies *(Including education classes furnished by a Participating Provider; and select diabetes supplies when purchased by a Participating DME provider)*	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	
Inpatient hospital	20% coinsurance after deductible
Outpatient office visits	Face-to-Face visits: 20% coinsurance after deductible Telehealth/virtual: $10 copayment after deductible
Prescription drug coverage *Visit **priorityhealth.com** and search **Approved Drug** list to see a list of covered drugs and pricing information. Select optimized.*	
Tier 1a / Tier 1b	$5 / $35 copayment, after deductible; Mail order - 90-day supply for 2 copayments

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

Additional Benefits

Cost estimator: A valuable tool in your online account that displays the in-network facilities charge for common services along with your out-of-pocket cost share based on your plan - putting you in control of your health care costs.

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