

Benefits summary:

HMO PriorityValue



Coverage period: 01.01.2027 to 12.31.2027

Delivering broad coverage with greater member engagement

CC Interholdings LLC DBA Continental Hospital

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 <i>The amount you pay before we begin to pay.</i>	\$6,000 individual/\$12,000 family Out-of-network services not covered.
Coinsurance <i>Your share of the costs of a covered health care service.</i>	30% coinsurance for services after deductible is met, except where noted. Out-of-network services not covered.
Coinsurance maximum <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 limit.</i>	Not applicable
Out-of-pocket limit <i>The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.</i>	\$10,150 individual/\$20,300 family
Office visits	
Primary care provider (PCP)	No charge for evaluation & management services
Specialists	30% coinsurance after deductible
Urgent care	30% coinsurance after deductible
Virtual Care Services <i>For medical and behavioral health visits</i>	No charge
Allergy testing, serum and injections	30% coinsurance after deductible
Retail health clinic <i>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)</i>	30% coinsurance after deductible
Mental and behavioral health	
Inpatient hospital	30% coinsurance after deductible
Outpatient office visits	30% coinsurance after deductible

continued	
Prescription drug coverage	
Visit priorityhealth.com and search <i>Optimized</i> or <i>Traditional</i> in the Approved Drug list to see coverage and pricing information.	
Formulary	Traditional
Tier 1	\$15 copayment; deductible N/A
Tier 2	\$50 copayment; deductible N/A
Tier 3	\$80 copayment; deductible N/A
Tier 4	\$50 copayment; deductible N/A
Tier 5	\$80 copayment; deductible N/A
Mail Order / Retail	Tier 1/2/3 90-day supply = Mail Order 2.5x, deductible N/A / Retail 3x, deductible N/A
Preventive care	
Preventive care, immunizations	No charge; 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	30% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	30% coinsurance after deductible
Laboratory	No charge
Emergency services	
Emergency room	30% coinsurance after deductible
Emergency transportation/ ambulance services	30% coinsurance after deductible
Hospital care	
Inpatient hospital physician services	30% coinsurance after deductible
Surgery and/or facility fee	30% coinsurance after deductible; exceptions apply
Bariatric surgery	30% coinsurance after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	30% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	30% coinsurance after deductible
In-home and hospice care	30% coinsurance after deductible
Rehabilitation services and devices	
Physical and occupational therapy	30% coinsurance after deductible Combined maximum 60 visits per member per contract year
Chiropractic care	30% coinsurance after deductible Maximum 30 visits per member per contract year
Speech therapy	30% coinsurance after deductible; Maximum 60 visits per member per contract year
Prosthetic and orthotic support	No charge
Durable medical equipment (DME)	No charge
Family planning and maternity care	
Family planning	30% coinsurance after deductible
Routine prenatal and postpartum care	No charge for evaluation and management; see Preventative Health Care Guidelines for recommendations and services
Maternity delivery and nursery care	30% coinsurance after deductible
Tubal ligation	No charge for physician's 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	30% coinsurance after deductible

Riders

Oral and non-oral treatments for sexual dysfunction, 50% copay	Must be filled by participating pharmacy. These must be authorized. Coverage is limited to: oral tablets, injectable, and intra-urethral.
Elective Termination of Pregnancy	May use any participating provider during the first trimester of the pregnancy, no referral required, limited one procedure during any one period of 24 consecutive months.
Rehabilitative medicine	30 additional visits from the standard 30 visits. Does not include chiropractic visits.
Weight loss Rx	Covers certain weight loss drugs
Private Duty Nursing	Adds coverage at the plan's member coinsurance after deductible for Private Duty Nursing up to a benefit maximum of 30 days per contract year. Prior Authorization is required.
PSA test rider	Covers the PSA (prostate specific antigen) test at no charge; after deductible for HSA. This is a blood test used to screen for prostate cancer.
Habilitation Services	Adds habilitation coverage for Physical and Occupational Therapy and Speech Therapy services not related to Autism Spectrum Disorder.

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.