

Benefits summary:

POS 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	Preferred benefits	Alternate benefits
Deductible <i>The amount you pay before we begin to pay.</i>	\$6,000 individual/\$12,000 family	\$12,000 individual/\$24,000 family
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.	50% coinsurance for services after deductible is met, except where noted.
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	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>	\$8,550 individual/\$17,100 family	\$17,100 individual/\$34,200 family
Office visits	Preferred benefits	Alternate benefits
Primary care provider (PCP)	No charge for evaluation & management services	50% coinsurance after deductible
Specialists	30% coinsurance after deductible	50% coinsurance after deductible
Urgent care	30% coinsurance after deductible	50% coinsurance after deductible
Virtual Care Services <i>For medical and behavioral health visits</i>	No charge	50% coinsurance after deductible
Allergy testing, serum and injections	30% coinsurance after deductible	50% 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	30% coinsurance after deductible
Mental and behavioral health	Preferred benefits	Alternate benefits
Inpatient hospital	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient office visits	30% coinsurance after deductible	50% coinsurance after deductible

continued

Prescription drug coverage

Visit priorityhealth.com and search *Optimized* or *Traditional* 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	Preferred benefits	Alternate benefits
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	50% coinsurance after deductible
Laboratory and X-ray	Preferred benefits	Alternate benefits
Radiology	30% coinsurance after deductible	50% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	30% coinsurance after deductible	50% coinsurance after deductible
Laboratory	No charge	50% coinsurance after deductible
Emergency services	Preferred benefits	Alternate benefits
Emergency room	30% coinsurance after deductible	30% coinsurance after deductible
Emergency transportation/ ambulance services	30% coinsurance after deductible	30% coinsurance after deductible
Hospital care	Preferred benefits	Alternate benefits
Inpatient hospital physician services	30% coinsurance after deductible	50% coinsurance after deductible
Surgery and/or facility fee	30% coinsurance after deductible; exceptions apply	50% coinsurance after deductible; exceptions apply
Bariatric surgery	30% coinsurance after deductible; covered once per lifetime	50% coinsurance after deductible; covered once per lifetime
Outpatient care	Preferred benefits	Alternate benefits
Skilled nursing services and residential treatment	30% coinsurance after deductible; Up to 45 days covered per member each contract year	50% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	30% coinsurance after deductible	50% coinsurance after deductible
In-home and hospice care	30% coinsurance after deductible	50% coinsurance after deductible
Rehabilitation services and devices	Preferred benefits	Alternate benefits
Physical and occupational therapy	30% coinsurance after deductible Maximum 60 visits per member per contract year, combined Preferred and Alternate	50% coinsurance after deductible Maximum 60 visits per member per contract year, combined Preferred and Alternate
Chiropractic care	30% coinsurance after deductible Maximum 30 visits per member per contract year, combined Preferred and Alternate	50% coinsurance after deductible Maximum 30 visits per member per contract year, combined Preferred and Alternate
Speech therapy	30% coinsurance after deductible; Maximum 60 visits per member per contract year, combined Preferred and Alternate	50% coinsurance after deductible Maximum 60 visits per member per contract year, combined Preferred and Alternate
Prosthetic and orthotic support	No charge	50% coinsurance after deductible
Durable medical equipment (DME)	No charge	50% coinsurance after deductible

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Family planning and maternity care	Preferred benefits	Alternate benefits
Family planning	30% coinsurance after deductible	50% coinsurance after deductible
Routine prenatal and postpartum care	No charge for evaluation and management; see Preventative Health Care Guidelines for recommendations and services	50% coinsurance after deductible
Maternity delivery and nursery care	30% coinsurance after deductible	50% 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	50% coinsurance after deductible
Vasectomy	30% coinsurance after deductible	50% coinsurance after deductible

Riders	
Non-oral treatment for sexual dysfunction, 50% copay	Coverage is limited to the following: injectable and intra-urethral. Prescription must be certified by Priority Health.
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.