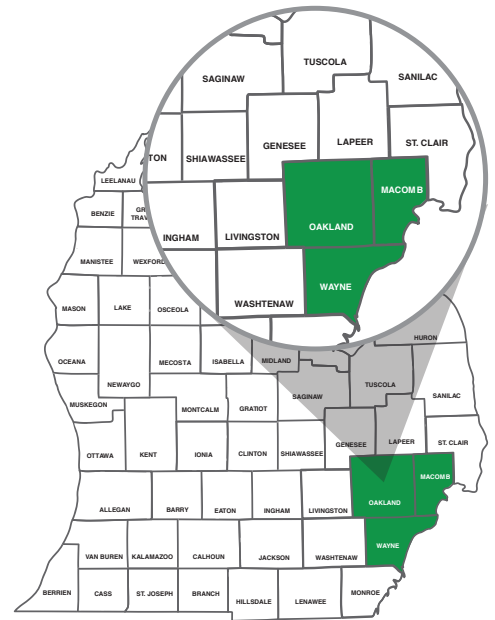


Ascension St. John Providence Network

Individuals who live in Wayne, Oakland and Macomb counties can purchase our Bronze, Silver and Gold plan options with the Ascension St. John Providence Network narrow network.



Why choose this narrow network option?

This narrow network option is designed to appeal to price-sensitive individuals who are willing to accept a limited network of providers in exchange for a lower monthly premium while still getting access to quality care within the Ascension St. John Providence health system.

Selling advantages

Unlike many competing narrow networks, all of our narrow network products feature:

- No referrals
- Provider-specific names to make it easier for you and your client to understand which facilities are covered
- No additional limits or restrictions on care or services

Included in this narrow network

- Ascension Macomb-Oakland Hospital – Madison Heights Campus
- Ascension Macomb-Oakland Hospital – Warren Campus
- Ascension River District Hospital
- Ascension Providence Rochester Hospital
- Ascension Providence Hospital – Novi Campus
- Ascension Providence Hospital – Southfield Campus
- Ascension St. John Hospital
- Physicians who are affiliated with the Ascension St. John Providence groups listed below:
 - St. John and St. John North Shore
 - St. John River District
 - St. John Oakland
 - St. John Macomb
 - St. John Cornerstone
 - Providence Hospital
- All in-network pharmacies



This plan requires members to receive care at facilities within the Ascension St. John Providence network of doctors and affiliated providers. Care received outside of the Ascension St. John Providence Network will not be covered, and members will be required to cover the full cost for out-of-network care.

*Reference your 2023
Priority Health rate book
for cost details.*

2023 MyPriority — Ascension St. John Providence HMO plan options

	MyPriority Bronze 9100	MyPriority Silver 3600	MyPriority Silver 5500	MyPriority Gold Copay+
Deductible Individual / family	\$9,100 / \$18,200	\$3,600 / \$7,200	\$5,500 / \$11,000	\$0 / \$0
Out-of-pocket limit Individual / family		\$9,100 / \$18,200	\$9,100 / \$18,200	\$9,100 / \$18,200
Coinsurance	Covered in full, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible	0% coinsurance
Office visits Primary doctor	\$30 copay; office visits (evaluation only), before deductible	\$30 copay; office visits (evaluation only), before deductible	\$30 copay; office visits (evaluation only) before deductible	\$20 copay; unlimited office visits (evaluation only)
Office visits Urgent care	\$75 copay; office visits (evaluation only), before deductible	\$75 copay; office visits (evaluation only), before deductible	\$75 copay; office visits (evaluation only), before deductible	\$75 copay; unlimited office visits (evaluation only)
Office visits Retail health clinic	\$75 copay; office visits (evaluation only), before deductible	\$75 copay; office visits (evaluation only), before deductible	\$75 copay; office visits (evaluation only), before deductible	\$75 copay; unlimited office visits (evaluation only)
Office visits Specialist	\$90 copay; office visits (evaluation only), before deductible	\$90 copay; office visits (evaluation only), before deductible	\$65 copay; office visits (evaluation only), before deductible	\$45 copay; office visits (evaluation only)
Office visits Mental health	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$20 copay; office visits only
Limited virtual care services 24/7 access to a provider with a Spectrum Health On-Demand Video Visit	Covered in full, before deductible	Covered in full, before deductible	Covered in full, before deductible	Covered in full
Maternity	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full
Inpatient hospital care (includes labor and delivery)	Covered in full, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible	\$1,000 copay per day (maximum 5 copayments)
Outpatient surgery	Covered in full, after deductible	\$1,000 copay; 30% coinsurance, after deductible	\$1,000 copay; 30% coinsurance, after deductible	\$1,000 copay
Emergency services	Covered in full, after deductible	\$250 copay (waived if admitted); 30% coinsurance, after deductible	\$250 copay (waived if admitted); 30% coinsurance, after deductible	\$250 copay (waived if admitted)
Prescription Drug Coverage <i>Want to find out if your prescription drug is covered? Visit priorityhealth.com and click on approved drug list.</i>				
Tier 1a	\$5 copay, before deductible	\$5 copay, before deductible	\$5 copay, before deductible	\$5 copay
Tier 1b	\$20 copay, before deductible	\$20 copay, before deductible	\$20 copay, before deductible	\$20 copay
Tier 2		\$75 copay, after deductible	\$75 copay, before deductible	\$75 copay
Tier 3	Covered in full, after deductible	\$100 copay, after deductible	\$125 copay, before deductible	\$100 copay
Tier 4 & 5		50% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance

2023 MyPriority — Ascension St. John Providence HSA and standard plan options

	MyPriority HSA Bronze 7100	MyPriority HSA Silver 3000 <i>Off-Marketplace</i>	MyPriority Standard Bronze 7500	MyPriority Standard Silver 5800	MyPriority Standard Gold 2000
Deductible Individual / family	\$7,100 / \$14,200	\$3,000 / \$6,000	\$7,500 / \$15,000	\$5,800 / \$11,600	\$2,000 / \$4,000
Out-of-pocket limit Individual / family		\$7,100 / \$14,200	\$9,000 / \$18,000	\$8,900 / \$17,800	\$8,700 / \$17,400
Coinsurance	Covered in full, after deductible	30% coinsurance, after deductible	50% coinsurance, after deductible	40% coinsurance, after deductible	25% coinsurance, after deductible
Office visits Primary doctor	Covered in full, after deductible	30% coinsurance, after deductible	\$50 Copay, office visits (evaluation only), before deductible	\$40 Copay, office visits (evaluation only), before deductible	\$30 Copay, office visits (evaluation only), before deductible
Office visits Urgent care			\$75 Copay, office visits (evaluation only), before deductible	\$60 Copay, office visits (evaluation only), before deductible	\$45 Copay, office visits (evaluation only), before deductible
Office visits Retail health clinic			\$75 Copay, office visits (evaluation only), before deductible	\$60 Copay, office visits (evaluation only), before deductible	\$45 Copay, office visits (evaluation only), before deductible
Office visits Specialist			\$100 Copay, office visits (evaluation only), before deductible	\$80 Copay, office visits (evaluation only), before deductible	\$60 Copay, office visits (evaluation only), before deductible
Office visits Mental health			\$50 Copay, office visits (evaluation only), before deductible	\$40 Copay, office visits (evaluation only), before deductible	\$30 Copay, office visits (evaluation only), before deductible
Limited virtual care services 24/7 access to a provider with a Spectrum Health On-Demand Video Visit	Covered in full, after deductible	Covered in full, after deductible	Covered in full, before deductible	Covered in full, before deductible	Covered in full, before deductible
Maternity	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible
Inpatient hospital care <i>(includes labor and delivery)</i>	Covered in full, after deductible	30% coinsurance, after deductible	50% coinsurance, after deductible	40% coinsurance, after deductible	25% coinsurance, after deductible
Outpatient surgery	Covered in full, after deductible	30% coinsurance, after deductible	50% coinsurance, after deductible	40% coinsurance, after deductible	25% coinsurance, after deductible
Emergency services	Covered in full, after deductible	30% coinsurance, after deductible	50% coinsurance, after deductible	40% coinsurance, after deductible	25% coinsurance, after deductible
Prescription Drug Coverage	Want to find out if your prescription drug is covered? Visit priorityhealth.com and click on approved drug list.				
Tier 1a	Covered in full, after deductible	30% coinsurance, after deductible	\$25 Copay, before deductible	\$20 Copay, before deductible	\$15 Copay, before deductible
Tier 1b			\$25 Copay, before deductible	\$20 Copay, before deductible	\$15 Copay, before deductible
Tier 2			\$50 Copay, after deductible	\$40 Copay, before deductible	\$30 Copay, before deductible
Tier 3			\$100 Copay, after deductible	\$80 Copay, after deductible	\$60 Copay, before deductible
Tier 4 & 5			\$500 Copay, after deductible	\$350 Copay, after deductible	\$250 Copay, before deductible



Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم: 711).