Plan ID 933451

Benefits summary:

PPO Copay Align

Priority Health

Coverage period: 01.01.2026 to 12.31.2026

Offering the most coverage available before deductible

MASTRONARDI PRODUCE USA INC

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	In-network benefits	Out-of-network benefits
Deductible *The amount you pay before we begin to pay.*	$500 individual/$1,000 family	$1,000 individual/$2,000 family
Coinsurance *Your share of the costs of a covered health care service.*	20% coinsurance for services after deductible is met, except where noted.	40% coinsurance for 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 limit.*	Not applicable	Not applicable
Out-of-pocket limit *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$4,000 individual/$8,000 family	$8,000 individual/$16,000 family
Office visits	**In-network benefits**	**Out-of-network benefits**
Primary care provider (PCP)	$20 copayment, deductible doesn't apply	40% coinsurance after deductible
Specialists	$40 copayment, deductible doesn't apply	40% coinsurance after deductible
Urgent care	$20 copayment, deductible doesn't apply	40% coinsurance after deductible
Virtual Care Services *For medical and behavioral health visits*	Covered in full	40% coinsurance after deductible
Allergy testing, serum and injections	Covered in full	40% coinsurance after deductible
Retail health clinic *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)*	$20 copayment, deductible doesn't apply	$20 copayment, deductible doesn't apply
Mental and behavioral health	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient office visits	$20 copayment, deductible doesn't apply	40% coinsurance after deductible

Prescription drug coverage *Visit priorityhealth.com and search Optimized or Traditional in the **Approved Drug** list to see coverage and pricing information.*		
Formulary	Optimized	
Tier 1	$15 copayment; deductible N/A	
Tier 2	$30 copayment; deductible N/A	
Tier 3	$60 copayment; deductible N/A	
Tier 4	20% coinsurance, $200 max; deductible N/A	
Tier 5	20% coinsurance, $400 max; deductible N/A	
Mail Order / Retail	Tier 1/2/3 90-day supply = Mail Order 2x, deductible N/A / Retail 3x, deductible N/A	
Preventive care	**In-network benefits**	**Out-of-network benefits**
Preventive care, immunizations	Covered in full; 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	40% coinsurance after deductible
Laboratory and X-ray	**In-network benefits**	**Out-of-network benefits**
Radiology	20% coinsurance after deductible	40% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full	40% coinsurance after deductible
Laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Emergency services	**In-network benefits**	**Out-of-network benefits**
Emergency room	$500 copayment, deductible doesn't apply	$500 copayment, deductible doesn't apply
Emergency transportation/ ambulance services	Covered in full	Covered in full
Hospital care	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital physician services	20% coinsurance after deductible	40% coinsurance after deductible
Surgery and/or facility fee	20% coinsurance after deductible; exceptions apply	40% coinsurance after deductible; exceptions apply
Bariatric surgery	20% coinsurance after deductible; covered once per lifetime	40% coinsurance after deductible; covered once per lifetime
Outpatient care	**In-network benefits**	**Out-of-network benefits**
Skilled nursing services and residential treatment	20% coinsurance after deductible; Up to 120 days covered per member each contract year	40% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible
In-home and hospice care	Covered in full after deductible	40% coinsurance after deductible
Rehabilitation services and devices	**In-network benefits**	**Out-of-network benefits**
Physical and occupational therapy	$20 copayment, deductible doesn't apply Maximum 60 visits per member per contract year, combined In and Out of Network	50% coinsurance after deductible Maximum 60 visits per member per contract year, combined In and Out of Network
Chiropractic care	$20 copayment, deductible doesn't apply Maximum 12 visits per member per contract year, combined In and Out of Network	50% coinsurance after deductible Maximum 12 visits per member per contract year, combined In and Out of Network
Speech therapy	$20 copayment, deductible doesn't apply; Maximum 60 visits per member per contract year, combined In and Out of Network	50% coinsurance after deductible Maximum 60 visits per member per contract year, combined In and Out of Network
Prosthetic and orthotic support	20% coinsurance after deductible	50% coinsurance after deductible
Durable medical equipment (DME)	20% coinsurance after deductible	50% coinsurance after deductible

Family planning and maternity care	In-network benefits	Out-of-network benefits
Family planning	50% coinsurance after deductible	50% coinsurance after deductible
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services	40% coinsurance after deductible
Maternity delivery and nursery care	20% coinsurance after deductible	40% coinsurance after deductible
Tubal ligation	Covered in full 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	40% coinsurance after deductible
Vasectomy	Covered in full in physician's office. Inpatient or outpatient facilities are subject to deductible and coinsurance.	40% coinsurance after deductible

Riders	
Oral and non-oral treatment for sexual dysfunction – matching drug copay	Coverage is limited to the following: injectable, intra-urethral and oral tablets. Prescription must be certified by Priority Health.
Durable medical equipment	80% coverage
Prosthetics and orthotics	80% coverage
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.
Chiropractic visits	12 visits
Skilled Nursing Facility	Skilled nursing facility services are covered up to 120 days.

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.