Plan ID 765084

Benefits summary:

POS PriorityHSA

Empowering members to take greater control of their health care spending

Priority Health

Coverage period: 01.01.2024 to 12.31.2024

BENZIE COUNTY CENTRAL SCHOOLS

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
Aggregate Deductible *The amount you pay before we begin to pay.*	$1,600 individual/$3,200 family	$3,200 individual/$6,400 family
Coinsurance *Your share of the costs of a covered health care service.*	No cost for services after deductible is met, except where noted.	20% 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.*	$2,200 individual/$4,400 family	$4,400 individual/$8,800 family
Office visits	**Preferred benefits**	**Alternate benefits**
Primary care provider (PCP)	Covered in full after deductible	20% coinsurance after deductible
Specialists	Covered in full after deductible	20% coinsurance after deductible
Urgent care	Covered in full after deductible	20% coinsurance after deductible
Virtual Care Services *For medical and behavioral health visits*	Covered in full after deductible	20% coinsurance after deductible
Allergy testing, serum and injections	Covered in full after deductible	20% 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)*	Covered in full after deductible	Covered in full after deductible
Mental and behavioral health	**Preferred benefits**	**Alternate benefits**
Inpatient hospital	Covered in full after deductible	20% coinsurance after deductible
Outpatient office visits	Covered in full after deductible	20% 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	Traditional	
Tier 1	$10 copayment; after deductible	
Tier 2	$40 copayment; after deductible	
Tier 3	$40 copayment; after deductible	
Tier 4	$40 copayment; after deductible	
Tier 5	$40 copayment; after deductible	
Mail Order	Tier 1/2/3 = 2x, after deductible	
Preventive care	**Preferred benefits**	**Alternate 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	20% coinsurance after deductible
Laboratory and X-ray	**Preferred benefits**	**Alternate benefits**
Radiology	Covered in full after deductible	20% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible	20% coinsurance after deductible
Laboratory	Covered in full after deductible	20% coinsurance after deductible
Emergency services	**Preferred benefits**	**Alternate benefits**
Emergency room	Covered in full after deductible	Covered in full after deductible
Emergency transportation/ ambulance services	Covered in full after deductible	Covered in full after deductible
Hospital care	**Preferred benefits**	**Alternate benefits**
Inpatient hospital physician services	Covered in full after deductible; exceptions apply	20% coinsurance after deductible
Surgery and/or facility fee	Covered in full after deductible; exceptions apply	20% coinsurance after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime	20% coinsurance after deductible; covered once per lifetime
Outpatient care	**Preferred benefits**	**Alternate benefits**
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 90 days covered per member each contract year	20% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible	20% coinsurance after deductible
In-home and hospice care	Covered in full after deductible	20% coinsurance after deductible
Rehabilitation services and devices	**Preferred benefits**	**Alternate benefits**
Physical and occupational therapy	Covered in full after deductible Maximum 50 visits per member per contract year, combined Preferred and Alternate	20% coinsurance after deductible Maximum 50 visits per member per contract year, combined Preferred and Alternate
Chiropractic care	Covered in full after deductible Maximum 30 visits per member per contract year, combined Preferred and Alternate	20% coinsurance after deductible Maximum 30 visits per member per contract year, combined Preferred and Alternate
Speech therapy	Covered in full after deductible; Maximum 50 visits per member per contract year, combined Preferred and Alternate	20% coinsurance after deductible Maximum 50 visits per member per contract year, combined Preferred and Alternate
Prosthetic and orthotic support	Covered in full after deductible	50% coinsurance after deductible
Durable medical equipment (DME)	Covered in full after deductible	50% coinsurance after deductible

Family planning and maternity care	Preferred benefits	Alternate 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 after deductible	20% coinsurance after deductible
Maternity delivery and nursery care	Covered in full after deductible	20% coinsurance after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient charges are subject to deductible and coinsurance when in connection with delivery or other covered inpatient surgery	20% coinsurance after deductible
Vasectomy	Covered in full when performed in physician's office or in connection with other surgery after deductible	20% 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	100% coverage
Prosthetics and orthotics	100% coverage
Hearing	One hearing test plus one hearing aid every 36 contract months; in network only.
Rehabilitative medicine	20 additional visits from the standard 30 visits. Does not include chiropractic visits.
Skilled Nursing Facility	Skilled nursing facility services are covered up to 90 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.

Travel assistance: If you become ill or injured while traveling more than 100 miles from home, AssistAmerica® coverage is included in your plan. Receive help with medical care, coordinating prescriptions, assistance with lost luggage, and even arrange your travel back home.