Benefits summary:
PPO PriorityHSA

PriorityHealth

Coverage period: 07.01.2021 to 06.30.2022

Empowering members to take greater control of their health care spending *Sanilac Intermediate School District*

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.

Benefits described in this benefit summary, including any coverage attachments, are based on a calendar year Benefit Year (January 1 through December 31) rather than a Contract Year. This means any of the following are administered on a "per calendar year" basis instead of per contract year:

- **Deductibles**
- **Coinsurance maximums**
- **Out-of-pocket limits**
- **Any other maximum dollar, day or visit limitations**

Member cost-sharing	In-network benefits	Out-of-network benefits
Deductible *The amount you pay before we begin to pay.*	$2,000 individual/$4,000 family Deductible costs don't apply towards your coinsurance maximum.	$4,000 individual/$8,000 family Deductible costs don't apply towards your coinsurance maximum.
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 calendar 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 calendar year for covered services before we begin to pay 100% of the costs.*	$3,000 individual/$6,000 family	$6,000 individual/$12,000 family
Office visits	**In-network benefits**	**Out-of-network 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 *24/7 care for non-emergency medical conditions*	Covered in full	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	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital	Covered in full after deductible	20% coinsurance after deductible
Outpatient office visits	Covered in full after deductible	20% coinsurance after deductible

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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	Covered in full after deductible	
Tier 2	Covered in full after deductible	
Tier 3	Covered in full after deductible	
Tier 4	Covered in full after deductible	
Tier 5	Covered in full after deductible	
Mail Order	Tier 1/2/3 = 2x, after deductible	
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	20% coinsurance after deductible
Laboratory and X-ray	**In-network benefits**	**Out-of-network 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	**In-network benefits**	**Out-of-network 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	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital physician services	Covered in full; exceptions apply after deductible	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	**In-network benefits**	**Out-of-network benefits**
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each calendar year	20% coinsurance after deductible; Up to 45 days covered per member each calendar 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	**In-network benefits**	**Out-of-network benefits**
Physical and occupational therapy	Covered in full after deductible Maximum 30 visits per member per calendar year, combined In and Out of Network	20% coinsurance after deductible Maximum 30 visits per member per calendar year, combined In and Out of Network
Chiropractic care	Covered in full after deductible Maximum 30 visits per member per calendar year, combined In and Out of Network	20% coinsurance after deductible Maximum 30 visits per member per calendar year, combined In and Out of Network
Speech therapy	Covered in full after deductible; Maximum 30 visits per member per calendar year, combined In and Out of Network	20% coinsurance after deductible Maximum 30 visits per member per calendar year, combined In and Out of Network
Prosthetic and orthotic support	10% coinsurance after deductible	50% coinsurance after deductible
Durable medical equipment (DME)	10% coinsurance after deductible	50% coinsurance after deductible

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Family planning and maternity care	**In-network benefits**	**Out-of-network benefits**
Family planning	Covered in full after deductible	20% coinsurance after deductible
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services	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	90% coverage
Prosthetics and orthotics	90% 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.
Chiropractic visits	30 visits

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.