Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2022 - 06/30/2023

PriorityHealth : **WARREN WOODS PUBLIC SCHOOLS**
Priority HSA PPO $1500 100%

Coverage for: Subscriber/Dependent | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. Note: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, visit us at PriorityHealth.com or call 1-888-389-6645. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-389-6645 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	For network providers $1,500 person / $3,000 family. For non-network providers $3,000 person / $6,000 family. The deductible for each benefit level is calculated separately.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, the network benefits deductible doesn't apply to preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $1,500 person / $3,000 family. For non-network providers $3,000 person / $6,000 family. The out-of-pocket limit for each benefit level is calculated separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and any co-pays and co-insurance you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See PriorityHealth.com or call 1-888-389-6645 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	20% co-insurance/ visit	
	Specialist visit	No charge	20% co-insurance/ visit	
	Other practitioner office visit	•No charge for retail health clinics •50% co-insurance/ visit for family planning/ infertility services •50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery	•Evaluation/management services only at retail health clinics covered at the network benefit level •50% co-insurance/ visit for family planning/ infertility services •50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery	Prescription drug co-pay may also apply when selected injectable drugs are provided. Prescription drugs for infertility treatment covered only with prescription drug addendum.
	Preventive care/screening/ immunization	No charge	20% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Network benefit level deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance	Prior Authorization required for genetic testing.
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance	Prior Authorization required.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi	Generic drugs (Tier 1)	$15 co-pay/ retail prescription $37.50 co-pay/ mail order prescription	Not covered	Costs shown in the "What You Will Pay" columns apply to drugs on the approved drug list when obtained from a Participating Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription) Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable Copayments at a retail Participating Pharmacy. 50% co-insurance/ prescription for infertility drugs.
	Preferred brand drugs (Tier 2)	$50 co-pay/ retail prescription $125 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	$80 co-pay/ retail prescription $200 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs (Tier 4)	$50 co-pay/ retail prescription	Not covered	-----------none-----------
	Non-Preferred specialty drugs (Tier 5)	$80 co-pay/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% co-insurance/ visit	Including outpatient care, observation care and ambulatory surgery center care. Prior Authorization may be required. Prior Authorization is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fees	No charge	20% co-insurance/ visit	
If you need immediate medical attention	Emergency room services	No charge	Covered at the network benefit level; R&C limitations apply	-----------none-----------
	Emergency medical transportation	No charge	Covered at the network benefit level; R&C limitations apply	-----------none-----------
	Urgent care	No charge	20% co-insurance/ visit	-----------none-----------

Common Medical Events	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% co-insurance/ visit	Prior Authorization is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Notification must be provided for all admissions following emergency room care. Prior Authorization is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fee	No charge	20% co-insurance/ visit	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	No charge	20% co-insurance/ visit	No charge for first three visits with network provider within 90 days of discharge from a network hospital for mental health inpatient care. Including medication management visits.
	Mental/Behavioral health inpatient services	No charge	20% co-insurance/ visit	Including Residential Treatment and partial hospitalization. Except in an emergency, Prior Authorization required.
	Substance use disorder outpatient services	No charge	20% co-insurance/ visit	Including medication management visits.
	Substance use disorder inpatient services	No charge	20% co-insurance/ visit	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, Prior Authorization required.
If you are pregnant	Routine prenatal and postnatal care	No charge	20% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply to physician office services for complications of pregnancy.
	Delivery professional fees	No charge	20% co-insurance/ visit	-----------none-----------
	Delivery facility fees	No charge	20% co-insurance/ visit	-----------none-----------

Common Medical Events	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance/ visit	Including hospice care services; excluding rehabilitation and habilitation services. Prior Authorization required, except for hospice care.
	Rehabilitation services *not* for the treatment of Autism Spectrum Disorder	No charge	20% co-insurance/ visit	Physical and occupational therapy limited to a combined 50 visits per contract year. Osteopathic and chiropractic manipulation limited to a combined 30 visits per contract year. Speech therapy limited to a combined 50 visits per contract year. Cardiac and pulmonary rehabilitation limited to a combined 50 visits per contract year.
	Habilitation services for treatment of Autism Spectrum Disorder ***only***	No charge	20% co-insurance/ visit	Prior Authorization required for Applied Behavior Analysis (ABA). Covered services include Physical, Occupational, Speech Therapy and Applied Behavior Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered
	Skilled nursing care	No charge	20% co-insurance/ visit	Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 90 days per contract year when provided by a network provider. When services are provided by a non-network provider, services are limited to a combined 45 days per contract year. Prior Authorization required, except for hospice care.
	Durable medical equipment (DME)	No charge	50% co-insurance/ visit	Including rental, purchase or repair. Prior Authorization required for equipment over $1,000, all rentals and all shoe inserts.
	Prosthetics & orthotics	No charge	50% co-insurance/ visit	
	Hospice service	No charge	20% co-insurance/ visit	This benefit applies to hospice services provided in the home only. Any hospice services provided in a facility will be subject to the appropriate facility benefit.
If your child needs dental or eye care	Child eye exam	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered
	Child dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult & Child)	• Habilitation services not for the treatment of Autism Spectrum Disorder • Hearing aids • Long-term care	• Private-duty nursing • Routine eye care (Adult & Child) • Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)		
• Bariatric surgery • Chiropractic care	• Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility	• Non-emergency care when traveling outside the U.S. • Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov; the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Priority Health at 1-888-389-6645 or www.priorityhealth.com; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-389-6645.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-389-6645.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-888-389-6645.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-389-6645.

---------------------To see examples of how this plan might cover costs for a sample medical situation, see the next section---------------------

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments, and co-insurance) and excluded services under this plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,000**
- **Specialist co-insurance** **20%**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Co-payments	$60
Co-insurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,620**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,000**
- **Specialist co-insurance** **20%**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **50%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Co-payments	$1,100
Co-insurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,060**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3,000**
- **Specialist co-insurance** **20%**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **50%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Co-payments	$0
Co-insurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.