Benefits summary:

POS PriorityHSA

PriorityHealth

Coverage period: 09.01.2023 to 08.31.2024

Empowering members to take greater control of their health care spending

OTSEGO PUBLIC 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.*	$1,500 individual/$3,000 family	$3,000 individual/$6,000 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.*	$2,000 individual/$4,000 family	$4,000 individual/$8,000 family
Office visits	**Preferred benefits**	**Alternate benefits**
Primary care provider (PCP)	20% coinsurance after deductible	40% coinsurance after deductible
Specialists	20% coinsurance after deductible	40% coinsurance after deductible
Urgent care	20% coinsurance after deductible	40% coinsurance after deductible
Virtual Care Services *For medical and behavioral health visits*	Covered in full after deductible	40% coinsurance after deductible
Allergy testing, serum and injections	20% coinsurance after deductible	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% coinsurance after deductible	20% coinsurance after deductible
Mental and behavioral health	**Preferred benefits**	**Alternate benefits**
Inpatient hospital	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient office visits	20% coinsurance after deductible	40% coinsurance after deductible

continued

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	$80 copayment; after deductible	
Tier 4	$40 copayment; after deductible	
Tier 5	$80 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	40% coinsurance after deductible
Laboratory and X-ray	**Preferred benefits**	**Alternate benefits**
Radiology	20% coinsurance after deductible	40% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	20% coinsurance after deductible	40% coinsurance after deductible
Laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Emergency services	**Preferred benefits**	**Alternate benefits**
Emergency room	20% coinsurance after deductible	20% coinsurance after deductible
Emergency transportation/ ambulance services	20% coinsurance after deductible	20% coinsurance after deductible
Hospital care	**Preferred benefits**	**Alternate 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	**Preferred benefits**	**Alternate benefits**
Skilled nursing services and residential treatment	20% coinsurance after deductible; Up to 45 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	20% coinsurance after deductible	40% coinsurance after deductible
Rehabilitation services and devices	**Preferred benefits**	**Alternate benefits**
Physical and occupational therapy	20% coinsurance after deductible Maximum 50 visits per member per contract year, combined Preferred and Alternate	40% coinsurance after deductible Maximum 50 visits per member per contract year, combined Preferred and Alternate
Chiropractic care	20% coinsurance after deductible Maximum 30 visits per member per contract year, combined Preferred and Alternate	40% coinsurance after deductible Maximum 30 visits per member per contract year, combined Preferred and Alternate
Speech therapy	20% coinsurance after deductible; Maximum 50 visits per member per contract year, combined Preferred and Alternate	40% 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

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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	40% coinsurance after deductible
Maternity delivery and nursery care	20% coinsurance after deductible	40% 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	40% coinsurance after deductible
Vasectomy	20% coinsurance after deductible	40% coinsurance after deductible

Riders	
Hearing	One hearing test plus one hearing aid every 36 contract months; in network only.

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.