

Benefits summary:



Coverage period: 01.01.2026 to 12.31.2026

HMO Tiered Copay

ANN ARBOR PUBLIC SCHOOLS

Providing strong coverage for most commonly used benefits

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	
Deductible <i>The amount you pay before we begin to pay.</i>	\$500 individual/\$1,000 family Out-of-network services not covered.
Coinsurance <i>Your share of the costs of a covered health care service.</i>	20% coinsurance for services after deductible is met, except where noted. Out-of-network services not covered.
Coinsurance maximum <i>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.</i>	\$2,000 individual/\$4,000 family Deductible costs don't apply towards your coinsurance maximum.
Out-of-pocket limit <i>The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.</i>	\$9,200 individual/\$18,400 family
Office visits	
Primary care provider (PCP)	\$30 copayment, deductible doesn't apply
Specialists	\$50 copayment, deductible doesn't apply
Urgent care	\$75 copayment, deductible doesn't apply
Virtual Care Services <i>For medical and behavioral health visits</i>	Covered in full
Allergy testing, serum and injections	Covered in full
Retail health clinic <i>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)</i>	\$75 copayment, deductible doesn't apply
Mental and behavioral health	
Inpatient hospital	20% coinsurance after deductible
Outpatient office visits	\$30 copayment, deductible doesn't apply

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; deductible N/A
Tier 2	\$40 copayment; deductible N/A
Tier 3	\$80 copayment; deductible N/A
Tier 4	\$40 copayment; deductible N/A
Tier 5	\$80 copayment; 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	
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
Laboratory and X-ray	
Radiology	20% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible
Laboratory	20% coinsurance after deductible
Emergency services	
Emergency room	\$150 copayment after deductible
Emergency transportation/ ambulance services	\$150 copayment after deductible
Hospital care	
Inpatient hospital physician services	20% coinsurance after deductible
Surgery and/or facility fee	20% coinsurance after deductible; exceptions apply
Bariatric surgery	20% coinsurance after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 730 days per lifetime per member
Outpatient surgery	20% coinsurance after deductible
In-home and hospice care	Covered in full after deductible
Rehabilitation services and devices	
Physical and occupational therapy	\$30 copayment, deductible doesn't apply Combined maximum 50 visits per member per contract year
Chiropractic care	\$30 copayment, deductible doesn't apply Maximum 30 visits per member per contract year
Speech therapy	\$30 copayment, deductible doesn't apply; Maximum 50 visits per member per contract year
Prosthetic and orthotic support	20% coinsurance after deductible
Durable medical equipment (DME)	20% coinsurance after deductible
Family planning and maternity care	
Family planning	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
Maternity delivery and nursery care	20% 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
Vasectomy	Covered in full in physician's office. Inpatient or outpatient facilities are subject to deductible and coinsurance.

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	20 additional visits from the standard 30 visits. Does not include chiropractic visits.
Skilled Nursing Facility Services Lifetime Benefit	Increases maximum to 730 days per lifetime for non-hospital services: skilled nursing, subacute, inpatient rehab and hospice facilities. Out-of-pocket maximum applies to these services. Prior approval required. 100% coverage up to the benefit maximum.
Certain surgeries and treatments including bariatric	Covers physician fees at \$0 copayment. Facility fees covered at plan cost-share for certain surgeries and treatments.
Sponsored dependent*	Covers dependents otherwise not covered. Example: Foster children, parent, otherwise related or legal guardianship of dependent
Domestic partners, enhanced	Covers both same gender partner or different gender partner as a dependent.

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.