

# Benefits summary:



Coverage period: 07.01.2025 to 06.30.2026

## HMO PriorityHSA

*Empowering members to take greater control of their health care spending*

*Newaygo 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	
<b>Aggregate Deductible</b> <i>The amount you pay before we begin to pay.</i>	\$2,000 individual/\$4,000 family Out-of-network services not covered.
<b>Coinsurance</b> <i>Your share of the costs of a covered health care service.</i>	No cost for services after deductible is met, except where noted. Out-of-network services not covered.
<b>Coinsurance maximum</b> <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>	Not applicable
<b>Out-of-pocket limit</b> <i>The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.</i>	\$4,000 individual/\$8,000 family
Office visits	
<b>Primary care provider (PCP)</b>	Covered in full after deductible
<b>Specialists</b>	Covered in full after deductible
<b>Urgent care</b>	Covered in full after deductible
<b>Virtual Care Services</b> <i>For medical and behavioral health visits</i>	Covered in full after deductible
<b>Allergy testing, serum and injections</b>	Covered in full after deductible
<b>Retail health clinic</b> <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>	Covered in full after deductible
Mental and behavioral health	
<b>Inpatient hospital</b>	Covered in full after deductible
<b>Outpatient office visits</b>	Covered in full after deductible

**Prescription drug coverage**

Visit [priorityhealth.com](https://priorityhealth.com) and search *Optimized or Traditional* in the **Approved Drug** list to see coverage and pricing information.

<b>Formulary</b>	Traditional
<b>Tier 1</b>	\$10 copayment; after deductible
<b>Tier 2</b>	\$40 copayment; after deductible
<b>Tier 3</b>	\$80 copayment; after deductible
<b>Tier 4</b>	\$40 copayment; after deductible
<b>Tier 5</b>	\$80 copayment; after deductible
<b>Mail Order / Retail</b>	Tier 1/2/3 90-day supply = Mail Order 2x, after deductible / Retail 3x, after deductible
<b>Preventive care</b>	
<b>Preventive care, immunizations</b>	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
<b>Laboratory and X-ray</b>	
<b>Radiology</b>	Covered in full after deductible
<b>Advanced imaging (CT/ PET/MRI)</b>	Covered in full after deductible
<b>Laboratory</b>	Covered in full after deductible
<b>Emergency services</b>	
<b>Emergency room</b>	Covered in full after deductible
<b>Emergency transportation/ ambulance services</b>	Covered in full after deductible
<b>Hospital care</b>	
<b>Inpatient hospital physician services</b>	Covered in full after deductible; exceptions apply
<b>Surgery and/or facility fee</b>	Covered in full after deductible; exceptions apply
<b>Bariatric surgery</b>	Covered in full after deductible; covered once per lifetime
<b>Outpatient care</b>	
<b>Skilled nursing services and residential treatment</b>	Covered in full after deductible; Up to 90 days covered per member each contract year
<b>Outpatient surgery</b>	Covered in full after deductible
<b>In-home and hospice care</b>	Covered in full after deductible
<b>Rehabilitation services and devices</b>	
<b>Physical and occupational therapy</b>	Covered in full after deductible Combined maximum 60 visits per member per contract year
<b>Chiropractic care</b>	Covered in full after deductible Maximum 30 visits per member per contract year
<b>Speech therapy</b>	Covered in full after deductible; Maximum 60 visits per member per contract year
<b>Prosthetic and orthotic support</b>	20% coinsurance after deductible
<b>Durable medical equipment (DME)</b>	20% coinsurance after deductible
<b>Family planning and maternity care</b>	
<b>Family planning</b>	50% coinsurance after deductible
<b>Routine prenatal and postpartum care</b>	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services
<b>Maternity delivery and nursery care</b>	Covered in full after deductible
<b>Tubal ligation</b>	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
<b>Vasectomy</b>	Covered in full in physician's office after deductible. Inpatient or outpatient facilities are subject to deductible and coinsurance.

Riders	
Durable medical equipment	80% coverage
Prosthetics and orthotics	80% coverage
Rehabilitative medicine	30 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.