Summary of Benefits and Coverage

Benefits summary:

POS PriorityHSA

PriorityHealth

Coverage period: 09/01/2018 to 08/31/2019

Empowering members to take greater control of their health care spending

MASON COUNTY CENTRAL 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
Deductible *The amount you pay before we begin to pay.*	$1,350 individual/$2,700 family Deductible costs don't apply towards your coinsurance maximum	$3,000 individual/$6,000 family Deductible costs don't apply towards your coinsurance maximum
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 visits *24/7 care for non-emergency conditions*	Covered in full after deductible	Not covered
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

Summary of Benefits and Coverage

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	
Generic	$10 copayment after deductible	
Brand	$40 preferred copayment, $80 non-preferred copayment, after deductible	
Mail Order	Generic: 2x Brand: 2x; after deductible	
Specialty	$40 preferred copayment, $80 non-preferred copayment, 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 90 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 Combined maximum 30 visits per member per contract year	40% coinsurance after deductible Combined maximum 30 visits per member per contract year
Chiropractic care	Combined with physical and occupational therapy	Combined with physical and occupational therapy
Speech therapy	20% coinsurance after deductible; Combined maximum 30 visits per member per contract year	40% coinsurance after deductible Combined maximum 30 visits per member per contract year
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

Summary of Benefits and Coverage

continued		
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	Not covered

Riders	
Durable medical equipment	100% coverage
Prosthetics and orthotics	100% coverage

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.

Member perks: Earn up to 20% cash back when you purchase digital gift cards from hundreds of local and national retailers - from Amazon to Zappos. Redeem online or at checkout at the store.

Summary of Benefits and Coverage

Summary of Benefits and Coverage: What this Plan Covers & What it Costs — Coverage Period: 09/01/2018 - 08/31/2019

PriorityHealth : Mason County Central Schools HSA – POS 80% — **Coverage for: Subscriber/Dependent | Plan Type: POS**

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 1-800-446-5674. 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 1-800-446-5674 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	For participating providers $1,350 person / $2,700 family For non-participating 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 preferred 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?	Yes. For participating providers $2,000 person / $4,000 family For non-participating providers $4,000 person / $8,000 family The out-of-pocket limit for each benefit level is calculated separately. The maximum preferred out-of-pocket limit for any one individual within the family is $4,000.	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.
Does this plan use a network of providers?	Yes. See PriorityHealth.com or call 1-800-446-5674 for a list of participating 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 I need a referral to see a specialist?	No, you don't need a referral in order to receive the preferred benefit for services provided by a participating specialist. Yes, you do need a referral in order to receive the preferred benefit for services provided by a non-participating specialist.	You can see the in-network specialist you choose without a referral. This plan will pay some or all of the costs to see an out-of-network specialist for covered services but only if you have a referral before you see the specialist.

Summary of Benefits and Coverage

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: Participating Provider (You will pay the least)	What You Will Pay: Non-Participating 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	20% co-insurance/ visit	40% co-insurance/ visit	Prescription drug co-pay may also apply when selected injectable drugs are provided. Prescription drugs for infertility treatment covered only with prescription drug addendum. Retail health clinic services are covered at reasonable and customary charges.
	Specialist visit	20% co-insurance/ visit	40% co-insurance/ visit	
	Other practitioner office visit	• 20% co-insurance/ visit for evaluation/ management services only at 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 preferred benefit level • Family planning/ infertility services not covered • 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery	
	Preventive care/screening/ immunization	No charge	40% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Preferred 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)	20% co-insurance	40% co-insurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Prior Approval required for certain radiology examinations.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Summary of Benefits and Coverage

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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	$10 co-pay/ retail prescription $20 co-pay/ mail order prescription	Not covered	Costs shown in the "Your Cost" 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	$40 co-pay/ retail prescription $80 co-pay/ mail prescription	Not covered	
	Non-preferred brand drugs	$80 co-pay/ retail prescription $100 co-pay/ mail prescription	Not covered	
	Preferred specialty drugs	$40 co-pay/ retail prescription	Not covered	----------none----------
	Non-Preferred specialty drugs	$80 co-pay/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance/ visit	40% co-insurance/ visit	Including outpatient care, observation care and ambulatory surgery center care. Prior approval may be required. Prior approval 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	20% co-insurance/ visit	40% co-insurance/ visit	
If you need immediate medical attention	Emergency room services	20% co-insurance/ visit	Covered at the preferred benefit level	----------none----------
	Emergency medical transportation	20% co-insurance	Covered at the preferred benefit level	----------none----------
	Urgent care	20% co-insurance/ visit	40% co-insurance/ visit	Urgent Care services received from a Non-Participating Provider who is located outside of our Service Area are Covered at the Preferred Benefit level.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Summary of Benefits and Coverage

Common Medical Events	Services You May Need	What You Will Pay: Participating Provider (You will pay the least)	What You Will Pay: Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance/ visit	40% co-insurance/ visit	Prior Approval 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 approval 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	20% co-insurance/ visit	40% co-insurance/ visit	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance/ visit	40% co-insurance/ visit	No charge for first three visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. Including medication management visits.
	Mental/Behavioral health inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
	Substance use disorder outpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Prior Approval required for intensive outpatient treatment. Including medication management visits.
	Substance use disorder inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
If you are pregnant	Routine prenatal and postnatal care	No charge	40% 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 for physician office services or home visits and consultations for complications of pregnancy.
	Delivery and all inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	----------none----------

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth com

Summary of Benefits and Coverage

Common Medical Events	Services You May Need	What You Will Pay: Participating Provider (You will pay the least)	What You Will Pay: Non-Participating 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	20% co-insurance/ visit	40% co-insurance/ visit	Including hospice care services; excluding rehabilitation and habilitation services. Prior approval required except for hospice care services in the home.
	Rehabilitation services *not* for the treatment of Autism Spectrum Disorder	20% co-insurance/ visit	40% co-insurance/ visit	Physical and occupational therapy (Including osteopathic and chiropractic manipulation) limited to a combined 30 visits per contract year. Speech therapy limited to a combined 30 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits per contract year.
	Habilitation services for treatment of Autism Spectrum Disorder *only*	20% co-insurance/ visit	40% co-insurance/ visit	Prior Approval 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	20% co-insurance/ visit	40% 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. Prior approval required.
	Durable medical equipment (DME)	No charge	50% co-insurance/ visit	Including rental, purchase or repair. Prior Approval required for equipment over $1,000, all rentals and all shoe inserts.
	Prosthetics & orthotics	No charge	50% co-insurance/ visit	
	Hospice service	20% co-insurance/ visit	40% 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

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com

Summary of Benefits and Coverage

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	• Non-emergency care when traveling outside the U.S. • 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 • Emergency services provided outside the U.S.	• Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility	• 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 1-800-446-5674 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.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-446-5674.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-446-5674.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-446-5674.

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

Summary of Benefits and Coverage

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Co-payments	$60
Co-insurance	$2,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,640**

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	20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,823
Co-payments	$1,115
Co-insurance	$1,104
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,096**

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	20%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,504
Co-payments	$0
Co-insurance	$396
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.