Benefits summary:
POS PriorityHSA

PriorityHealth

Coverage period: 07.01.2021 to 06.30.2022

Empowering members to take greater control of their health care spending *St. Clair County Community College*

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 ma 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.*	$1,500 individual/$3,000 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.*	$3,000 individual/$6,000 family	$6,000 individual/$12,000 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 *24/7 care for non-emergency medical conditions*	Covered in full	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	$20 copayment; after deductible	
Tier 3	$20 copayment; after deductible	
Tier 4	$20 copayment; after deductible	
Tier 5	$20 copayment; after deductible	
Mail Order	Tier 1/2/3 = 2x, after deductible	
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	40% coinsurance after deductible
Laboratory and X ray		**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**	**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		
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 30 visits per member per contract year, combined Preferred and Alternate
	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 30 visits per member per contract year, combined Preferred and Alternate
Durable medical equipment (DME)	50% coinsurance after deductible	50% coinsurance after deductible

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	
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.
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

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 o 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.

Benefits summary:
POS PriorityHSA

PriorityHealth

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St. Clair County Community College

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Member cost sharing	Preferred benefits	Alternate benefits
Deductible *The amount you pay before we begin to pay.*	$2,000 individual/$4,000 family Deductible costs don't apply towards your coinsurance maximum.	$4,000 individual/$8,000 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.*	$4,000 individual/$8,000 family	$8,000 individual/$16,000 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 *24/7 care for non-emergency medical conditions*	Covered in full	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		
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		**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**	**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		
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 30 visits per member per contract year, combined Preferred and Alternate
	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 30 visits per member per contract year, combined Preferred and Alternate
Durable medical equipment (DME)	50% coinsurance after deductible	50% coinsurance after deductible

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	
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.
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

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 o 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.

Benefits summary:
HMO Traditional

PriorityHealth

Coverage period: 07.01.2021 to 06.30.2022

Delivering copay-based standard benefits

St. Clair County Community College

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Member cost sharing	
Deductible *The amount you pay before we begin to pay.*	$1,000 individual/$2,000 family Deductible costs don't apply towards your coinsurance maximum. Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	20% coinsurance for services after deductible is met, except where noted. Out-of-network services not covered.
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.*	$1,500 individual/$3,000 family
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.*	$8,150 individual/$16,300 family
Office visits	
Primary care provider (PCP)	$30 copayment, deductible doesn't apply
Specialists	$30 copayment after deductible
Urgent care	$30 copayment after deductible
Virtual Care Services *24/7 care for non-emergency medical conditions*	Covered in full
Allergy testing, serum and injections	Covered in full
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)*	$30 copayment after deductible
Mental and behavioral health	
Inpatient hospital	20% coinsurance after deductible
Outpatient office visits	$30 copayment, deductible doesn't apply

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; 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	Tier 1/2/3 = 2x, 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	Covered in full
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible
Laboratory	Covered in full
Emergency services	
Emergency room	$100 copayment after deductible
Emergency transportation/ ambulance services	$100 copayment after deductible
Hospital care	
Inpatient hospital physician services	Covered in full; exceptions apply
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	20% coinsurance after deductible; Up to 45 days covered per member each contract year
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 after deductible Combined maximum 50 visits per member per contract year
Chiropractic care	$30 copayment after deductible Maximum 30 visits per member per contract year
Speech therapy	$30 copayment after deductible; 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 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
Vasectomy	Covered in full when performed in physician's office or in connection with other surgery

continued	
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

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 o 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.

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HMO PriorityHSA

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Member cost sharing	
Deductible *The amount you pay before we begin to pay.*	$1,400 individual/$2,800 family Deductible costs don't apply towards your coinsurance maximum. Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	20% coinsurance for services after deductible is met, except where noted. Out-of-network services not covered.
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
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
Office visits	
Primary care provider (PCP)	20% coinsurance after deductible
Specialists	20% coinsurance after deductible
Urgent care	20% coinsurance after deductible
Virtual Care Services *24/7 care for non-emergency medical conditions*	Covered in full
Allergy testing, serum and injections	20% 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
Mental and behavioral health	
Inpatient hospital	20% coinsurance after deductible
Outpatient office visits	20% 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	$20 copayment; after deductible
Tier 3	$40 copayment; after deductible
Tier 4	$20 copayment; after deductible
Tier 5	$40 copayment; after deductible
Mail Order	Tier 1/2/3 = 2x, after deductible
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)	20% coinsurance after deductible
Laboratory	20% coinsurance after deductible
Emergency services	
Emergency room	20% coinsurance after deductible
Emergency transportation/ ambulance services	20% coinsurance 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	20% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	20% coinsurance after deductible
In-home and hospice care	20% coinsurance after deductible
Rehabilitation services and devices	
Physical and occupational therapy	20% coinsurance after deductible Combined maximum 50 visits per member per contract year
Chiropractic care	20% coinsurance after deductible Maximum 30 visits per member per contract year
Speech therapy	20% coinsurance after deductible; 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 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
Vasectomy	20% coinsurance after deductible

continued	
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

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