Medical Insurance



PriorityHealth

This is intended to be an easy to read summary of some highlights of your benefit plan options. For more detailed information, please see the plan documents. A Pharmacy Quick Reference Guide is also enclosed.

	Core Plan	Buy Up
Deductible	\$500 per member \$1000 per family per calendar year	\$250 per member \$500 per family per calendar year
Copays • Fixed Dollar Copay	Office visit: PCP/OB: \$20 Specialist: \$35 Urgent Care: \$75 ER and High Tech Radiology: \$150	Office visit: PCP/OB: \$20 Specialist: \$35 Urgent Care: \$75 ER and High Tech Radiology: \$150
Prescription Drugs	Copays: • \$15 Generic • \$50 Preferred Brand • \$80 Non-Preferred Brand • 20% Specialty to a max of \$150 or \$300 • 2 X Mail Order	Copays: • \$10 Generic • \$40 Preferred Brand • \$40 Non-Preferred Brand • \$40 Specialty • 2 X Mail Order
Coinsurance	80% coverage on most services, after deductible to a maximum of \$1,500 per single/\$3,000 per family	100% coverage on most services, after deductible
Maximum Out of Pocket Cost (including copays, deductibles and prescriptions): Preventive Services	\$7,150 per member \$14,300 per family 100% Coverage	\$7,150 per member \$14,300 per family 100% Coverage
Durable Medical Equipment Prosthetics and Orthotics	50% Coverage after deductible	50% Coverage after deductible
Cost Per Student (every 6 months)	Student Only: None Student plus one dependent: \$1,333.80 Student plus 2 or more dependents: \$1945.02	Student only: \$159.96 Student plus one dependent: \$1685.58 Student plus 2 or more dependents: \$2384.88

Hylant Group Disclaimer: The abbreviated outlines of benefits used throughout this document are not intended to express any legal opinion as to the nature of coverage. They are only visuals to a basic understanding of coverages and do not detail all the contract terms nor do they alter any contract conditions. Please read your contract for specific coverages, limitations, and exclusions and call us with questions.