Plan ID 996918

Benefits summary:

HMO Copay Align - Southeast MI Partners

Priority Health

Coverage period: 01.01.2027 to 12.31.2027

Offering the most coverage available before deductible

SOUTHGATE COMMUNITY 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	Tier 1	Tier 2
Deductible *The amount you pay before we begin to pay.*	$100 individual/$200 family Tier 1 deductible costs apply to Tier 1 only.	$2,000 individual/$4,000 family Tier 2 deductible costs apply to Tier 1 and Tier 2.
Coinsurance *Your share of the costs of a covered health care service.*	No cost for services after deductible is met, except where noted.	20% 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.*	$9,100 individual/$18,200 family	$9,100 individual/$18,200 family
Office visits	**Tier 1**	**Tier 2**
Primary care provider (PCP)	$20 copayment, deductible doesn't apply	$40 copayment, deductible doesn't apply
Specialists	$35 copayment, deductible doesn't apply	$70 copayment, deductible doesn't apply
Urgent care	$50 copayment, deductible doesn't apply	$100 copayment, deductible doesn't apply
Virtual Care Services *For medical and behavioral health visits*	Covered in full	Covered in full
Allergy testing, serum and injections	Covered in full	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)*	$50 copayment, deductible doesn't apply	$50 copayment, deductible doesn't apply
Mental and behavioral health	**Tier 1**	**Tier 2**
Inpatient hospital	Covered in full after deductible	20% coinsurance after deductible
Outpatient office visits	$20 copayment, deductible doesn't apply	$40 copayment, deductible doesn't apply

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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	20% coinsurance, $100 max; deductible N/A	
Tier 5	20% coinsurance, $200 max; 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	**Tier 1**	**Tier 2**
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	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	**Tier 1**	**Tier 2**
Radiology	Covered in full after deductible	20% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	$150 copayment, deductible doesn't apply	$300 copayment, deductible doesn't apply
Laboratory	Covered in full after deductible	20% coinsurance after deductible
Emergency services	**Tier 1**	**Tier 2**
Emergency room	$100 copayment, deductible doesn't apply	$100 copayment, deductible doesn't apply
Emergency transportation/ ambulance services	$150 copayment, deductible doesn't apply	$150 copayment, deductible doesn't apply
Hospital care	**Tier 1**	**Tier 2**
Inpatient hospital physician services	Covered in full after deductible; exceptions apply	20% coinsurance after deductible
Surgery and/or facility fee	Covered in full after deductible; exceptions apply	20% coinsurance after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime	20% coinsurance after deductible; covered once per lifetime
Outpatient care	**Tier 1**	**Tier 2**
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each contract year	20% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible	20% coinsurance after deductible
In-home and hospice care	Covered in full after deductible	Covered in full after deductible
Rehabilitation services and devices	**Tier 1**	**Tier 2**
Physical and occupational therapy	$20 copayment, deductible doesn't apply Maximum 30 visits per member per contract year, combined Tier 1 & Tier 2	$40 copayment, deductible doesn't apply Maximum 30 visits per member per contract year, combined Tier 1 & Tier 2
Chiropractic care	$20 copayment, deductible doesn't apply Maximum 30 visits per member per contract year, combined Tier 1 & Tier 2	$40 copayment, deductible doesn't apply Maximum 30 visits per member per contract year, combined Tier 1 & Tier 2
Speech therapy	$20 copayment, deductible doesn't apply; Maximum 30 visits per member per contract year, combined Tier 1 & Tier 2	$40 copayment, deductible doesn't apply Maximum 30 visits per member per contract year, combined Tier 1 & Tier 2
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

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continued		Plan ID 996918
Family planning and maternity care	**Tier 1**	**Tier 2**
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	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services
Maternity delivery and nursery care	Covered in full after deductible	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	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.	Covered in full in physician's office. Inpatient or outpatient facilities are subject to deductible and coinsurance.

Riders	
Durable medical equipment	100%/50% coverage
Prosthetics and orthotics	100%/50% coverage
Hearing Care	One hearing test plus one hearing aid every 36 contract months, not to exceed $500, deductible does not apply

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.

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Plan ID 996911

Benefits summary:

HMO PriorityHSA

Priority Health

Coverage period: 01.01.2027 to 12.31.2027

Empowering members to take greater control of their health care spending

SOUTHGATE COMMUNITY SCHOOLS

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Member cost-sharing	
Aggregate Deductible *The amount you pay before we begin to pay.*	$1,750 individual/$3,500 family Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	No cost 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)	Covered in full after deductible
Specialists	Covered in full after deductible
Urgent care	Covered in full after deductible
Virtual Care Services *For medical and behavioral health visits*	Covered in full after deductible
Allergy testing, serum and injections	Covered in full 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)*	Covered in full after deductible
Mental and behavioral health	
Inpatient hospital	Covered in full after deductible
Outpatient office visits	Covered in full after deductible

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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 / Retail	Tier 1/2/3 90-day supply = Mail Order 2x, after deductible / Retail 3x, 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	Covered in full after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible
Laboratory	Covered in full after deductible
Emergency services	
Emergency room	Covered in full after deductible
Emergency transportation/ ambulance services	Covered in full after deductible
Hospital care	
Inpatient hospital physician services	Covered in full after deductible; exceptions apply
Surgery and/or facility fee	Covered in full after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible
In-home and hospice care	Covered in full after deductible
Rehabilitation services and devices	
Physical and occupational therapy	Covered in full after deductible Combined maximum 30 visits per member per contract year
Chiropractic care	Covered in full after deductible Maximum 30 visits per member per contract year
Speech therapy	Covered in full after deductible; Maximum 30 visits per member per contract year
Prosthetic and orthotic support	Covered in full after deductible
Durable medical equipment (DME)	Covered in full 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	Covered in full 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 after deductible. Inpatient or outpatient facilities are subject to deductible and coinsurance.

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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	100% coverage
Prosthetics and orthotics	100% 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.

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.

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Plan ID 996915

Benefits summary:

HMO PriorityHSA

Priority Health

Coverage period: 01.01.2027 to 12.31.2027

Empowering members to take greater control of their health care spending

SOUTHGATE COMMUNITY SCHOOLS

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Member cost-sharing	
Aggregate Deductible *The amount you pay before we begin to pay.*	$2,000 individual/$4,000 family 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.*	$4,000 individual/$8,000 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 *For medical and behavioral health visits*	Covered in full after deductible
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

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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 / Retail	Tier 1/2/3 90-day supply = Mail Order 2x, after deductible / Retail 3x, 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 30 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 30 visits per member per contract year
Prosthetic and orthotic support	Covered in full after deductible
Durable medical equipment (DME)	Covered in full 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	20% coinsurance after deductible

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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	100% coverage
Prosthetics and orthotics	100% 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.

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.

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Benefits summary:

HMO PriorityHSA

Priority Health

Coverage period: 01.01.2027 to 12.31.2027

Empowering members to take greater control of their health care spending

SOUTHGATE COMMUNITY SCHOOLS

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Member cost-sharing	
Aggregate Deductible *The amount you pay before we begin to pay.*	$2,000 individual/$4,000 family Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	No cost 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.*	$4,000 individual/$8,000 family
Office visits	
Primary care provider (PCP)	Covered in full after deductible
Specialists	Covered in full after deductible
Urgent care	Covered in full after deductible
Virtual Care Services *For medical and behavioral health visits*	Covered in full after deductible
Allergy testing, serum and injections	Covered in full 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)*	Covered in full after deductible
Mental and behavioral health	
Inpatient hospital	Covered in full after deductible
Outpatient office visits	Covered in full after deductible

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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 / Retail	Tier 1/2/3 90-day supply = Mail Order 2x, after deductible / Retail 3x, 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	Covered in full after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible
Laboratory	Covered in full after deductible
Emergency services	
Emergency room	Covered in full after deductible
Emergency transportation/ ambulance services	Covered in full after deductible
Hospital care	
Inpatient hospital physician services	Covered in full after deductible; exceptions apply
Surgery and/or facility fee	Covered in full after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible
In-home and hospice care	Covered in full after deductible
Rehabilitation services and devices	
Physical and occupational therapy	Covered in full after deductible Combined maximum 30 visits per member per contract year
Chiropractic care	Covered in full after deductible Maximum 30 visits per member per contract year
Speech therapy	Covered in full after deductible; Maximum 30 visits per member per contract year
Prosthetic and orthotic support	Covered in full after deductible
Durable medical equipment (DME)	Covered in full 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	Covered in full 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 after deductible. Inpatient or outpatient facilities are subject to deductible and coinsurance.

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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	100% coverage
Prosthetics and orthotics	100% 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.

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.

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Benefits summary:

HMO PriorityHSA

Priority Health

Coverage period: 01.01.2027 to 12.31.2027

Empowering members to take greater control of their health care spending

SOUTHGATE COMMUNITY SCHOOLS

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Member cost-sharing	
Aggregate Deductible *The amount you pay before we begin to pay.*	$3,000 individual/$6,000 family 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.*	$5,000 individual/$10,000 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 *For medical and behavioral health visits*	Covered in full after deductible
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

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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 / Retail	Tier 1/2/3 90-day supply = Mail Order 2x, after deductible / Retail 3x, 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 30 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 30 visits per member per contract year
Prosthetic and orthotic support	Covered in full after deductible
Durable medical equipment (DME)	Covered in full 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	20% coinsurance after deductible

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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	100% coverage
Prosthetics and orthotics	100% 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.

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.

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Plan ID 996917

Benefits summary:

HMO PriorityHSA

Priority Health

Coverage period: 01.01.2027 to 12.31.2027

Empowering members to take greater control of their health care spending

SOUTHGATE COMMUNITY SCHOOLS

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Member cost-sharing	
Aggregate Deductible *The amount you pay before we begin to pay.*	$3,000 individual/$6,000 family Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	No cost 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.*	$5,000 individual/$10,000 family
Office visits	
Primary care provider (PCP)	Covered in full after deductible
Specialists	Covered in full after deductible
Urgent care	Covered in full after deductible
Virtual Care Services *For medical and behavioral health visits*	Covered in full after deductible
Allergy testing, serum and injections	Covered in full 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)*	Covered in full after deductible
Mental and behavioral health	
Inpatient hospital	Covered in full after deductible
Outpatient office visits	Covered in full after deductible

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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 / Retail	Tier 1/2/3 90-day supply = Mail Order 2x, after deductible / Retail 3x, 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	Covered in full after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible
Laboratory	Covered in full after deductible
Emergency services	
Emergency room	Covered in full after deductible
Emergency transportation/ ambulance services	Covered in full after deductible
Hospital care	
Inpatient hospital physician services	Covered in full after deductible; exceptions apply
Surgery and/or facility fee	Covered in full after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible
In-home and hospice care	Covered in full after deductible
Rehabilitation services and devices	
Physical and occupational therapy	Covered in full after deductible Combined maximum 30 visits per member per contract year
Chiropractic care	Covered in full after deductible Maximum 30 visits per member per contract year
Speech therapy	Covered in full after deductible; Maximum 30 visits per member per contract year
Prosthetic and orthotic support	Covered in full after deductible
Durable medical equipment (DME)	Covered in full 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	Covered in full 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 after deductible. Inpatient or outpatient facilities are subject to deductible and coinsurance.

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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	100% coverage
Prosthetics and orthotics	100% 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.

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.

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Plan ID 996912

Benefits summary:

PPO PriorityHSA

Priority Health

Coverage period: 01.01.2027 to 12.31.2027

Empowering members to take greater control of their health care spending

SOUTHGATE COMMUNITY 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	In-network benefits	Out-of-network benefits
Aggregate Deductible *The amount you pay before we begin to pay.*	$1,750 individual/$3,500 family	$3,500 individual/$7,000 family
Coinsurance *Your share of the costs of a covered health care service.*	No cost for services after deductible is met, except where noted.	20% 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	**In-network benefits**	**Out-of-network benefits**
Primary care provider (PCP)	Covered in full after deductible	20% coinsurance after deductible
Specialists	Covered in full after deductible	20% coinsurance after deductible
Urgent care	Covered in full after deductible	20% coinsurance after deductible
Virtual Care Services *For medical and behavioral health visits*	Covered in full after deductible	20% coinsurance after deductible
Allergy testing, serum and injections	Covered in full after deductible	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)*	Covered in full after deductible	Covered in full after deductible
Mental and behavioral health	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital	Covered in full after deductible	20% coinsurance after deductible
Outpatient office visits	Covered in full after deductible	20% coinsurance after deductible

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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 / Retail	Tier 1/2/3 90-day supply = Mail Order 2x, after deductible / Retail 3x, after deductible	
Preventive care	**In-network benefits**	**Out-of-network 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	20% coinsurance after deductible
Laboratory and X-ray	**In-network benefits**	**Out-of-network benefits**
Radiology	Covered in full after deductible	20% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible	20% coinsurance after deductible
Laboratory	Covered in full after deductible	20% coinsurance after deductible
Emergency services	**In-network benefits**	**Out-of-network benefits**
Emergency room	Covered in full after deductible	Covered in full after deductible
Emergency transportation/ ambulance services	Covered in full after deductible	Covered in full after deductible
Hospital care	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital physician services	Covered in full after deductible; exceptions apply	20% coinsurance after deductible
Surgery and/or facility fee	Covered in full after deductible; exceptions apply	20% coinsurance after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime	20% coinsurance after deductible; covered once per lifetime
Outpatient care	**In-network benefits**	**Out-of-network benefits**
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each contract year	20% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible	20% coinsurance after deductible
In-home and hospice care	Covered in full after deductible	20% coinsurance after deductible
Rehabilitation services and devices	**In-network benefits**	**Out-of-network benefits**
Physical and occupational therapy	Covered in full after deductible Maximum 30 visits per member per contract year, combined In and Out of Network	20% coinsurance after deductible Maximum 30 visits per member per contract year, combined In and Out of Network
Chiropractic care	Covered in full after deductible Maximum 30 visits per member per contract year, combined In and Out of Network	20% coinsurance after deductible Maximum 30 visits per member per contract year, combined In and Out of Network
Speech therapy	Covered in full after deductible; Maximum 30 visits per member per contract year, combined In and Out of Network	20% coinsurance after deductible Maximum 30 visits per member per contract year, combined In and Out of Network
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

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Family planning and maternity care	In-network benefits	Out-of-network 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	20% coinsurance after deductible
Maternity delivery and nursery care	Covered in full after deductible	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	20% coinsurance after deductible
Vasectomy	Covered in full in physician's office after deductible. Inpatient or outpatient facilities are subject to deductible and coinsurance.	20% coinsurance after deductible

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	100% coverage
Prosthetics and orthotics	100% 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.

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.

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Plan ID 996914

Benefits summary:

PPO PriorityHSA

Priority Health

Coverage period: 01.01.2027 to 12.31.2027

Empowering members to take greater control of their health care spending

SOUTHGATE COMMUNITY SCHOOLS

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Member cost-sharing	In-network benefits	Out-of-network benefits
Aggregate Deductible *The amount you pay before we begin to pay.*	$2,000 individual/$4,000 family	$3,500 individual/$7,000 family
Coinsurance *Your share of the costs of a covered health care service.*	No cost for services after deductible is met, except where noted.	20% 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	$5,500 individual/$11,000 family
Office visits	**In-network benefits**	**Out-of-network benefits**
Primary care provider (PCP)	Covered in full after deductible	20% coinsurance after deductible
Specialists	Covered in full after deductible	20% coinsurance after deductible
Urgent care	Covered in full after deductible	20% coinsurance after deductible
Virtual Care Services *For medical and behavioral health visits*	Covered in full after deductible	20% coinsurance after deductible
Allergy testing, serum and injections	Covered in full after deductible	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)*	Covered in full after deductible	Covered in full after deductible
Mental and behavioral health	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital	Covered in full after deductible	20% coinsurance after deductible
Outpatient office visits	Covered in full after deductible	20% coinsurance after deductible

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Laboratory and X-ray	**In-network benefits**	**Out-of-network benefits**
Radiology	Covered in full after deductible	20% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	Covered in full after deductible	20% coinsurance after deductible
Laboratory	Covered in full after deductible	20% coinsurance after deductible
Emergency services	**In-network benefits**	**Out-of-network benefits**
Emergency room	Covered in full after deductible	Covered in full after deductible
Emergency transportation/ ambulance services	Covered in full after deductible	Covered in full after deductible
Hospital care	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital physician services	Covered in full after deductible; exceptions apply	20% coinsurance after deductible
Surgery and/or facility fee	Covered in full after deductible; exceptions apply	20% coinsurance after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime	20% coinsurance after deductible; covered once per lifetime
Outpatient care	**In-network benefits**	**Out-of-network benefits**
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each contract year	20% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible	20% coinsurance after deductible
In-home and hospice care	Covered in full after deductible	20% coinsurance after deductible
Rehabilitation services and devices	**In-network benefits**	**Out-of-network benefits**
Physical and occupational therapy	Covered in full after deductible Maximum 30 visits per member per contract year, combined In and Out of Network	20% coinsurance after deductible Maximum 30 visits per member per contract year, combined In and Out of Network
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Durable medical equipment (DME)	Covered in full after deductible	50% coinsurance after deductible

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