**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2025 - 12/31/2025**

**WMHIP Mecosta Osceola ISD: 500 PHMO3**

**Coverage for: Subscriber/Dependent | Plan Type: PPO**

**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 the number on the back of your Priority Health ID card. 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 the number on the back of your Priority Health ID card to request a copy.

| Important Questions | Answers | Why this Matters |
|---|---|---|
| **What is the overall deductible?** | For network providers $500 person / $1,000 family.<br>For non-network providers $1,000 person / $2,000 family. | 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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes, the network 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?** | For network providers $4,500 person / $9,000 family.<br>For non-network providers $4,500 person / $9,000 family.<br>Your plan also has a co-insurance maximum.<br>For network providers $3,000 person / $6,000 family.<br>For non-network providers N/A. | 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, health care this plan doesn't cover, and services that exceed an annual day/visit limit. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See PriorityHealth.com<br>or call the number on the back of your Priority Health ID card for a list of network 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 you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 co-pay/ visit | 40% co-insurance/ visit | Network benefit level deductible does not apply. |
| | Specialist visit | $50 co-pay/ visit | 40% co-insurance/ visit | Network benefit level deductible does not apply. |
| | Preventive care/screening/ immunization | No charge | 40% co-insurance/ visit | Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines. Network benefit level deductible does not apply.<br>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 | Prior Certification may be required. |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | 40% co-insurance | Prior Certification required. |

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

| Common Medical Events | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi | Generic drugs (Tier 1) | $20 co-pay/ retail prescription<br>$40 co-pay/ mail order prescription | Not covered | Covers up to a 31-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription, excluding Specialty Drugs).<br>50% co-insurance/ prescription for infertility drugs.<br>Deductible does not apply. |
| | Preferred brand drugs (Tier 2) | $40 co-pay/ retail prescription<br>$80 co-pay/ mail order prescription | Not covered | |
| | Non-preferred brand drugs (Tier 3) | $80 co-pay/ retail prescription<br>$160 co-pay/ mail order prescription | Not covered | |
| | Preferred specialty drugs (Tier 4) | $40 co-pay/ retail prescription | Not covered | Deductible does not apply. |
| | Non-Preferred specialty drugs (Tier 5) | $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 Certification may be required. |
| | Physician/surgeon fees | 20% co-insurance/ visit | 40% co-insurance/ visit | |
| **If you need immediate medical attention** | Emergency room services | $150 co-pay/ visit | Covered at the network benefit level; R&C limitations apply | Co-pay waived if you become confined in a Hospital as an inpatient.<br>Network benefit level deductible does not apply. |
| | Emergency medical transportation | 20% co-insurance | Covered at the network benefit level; R&C limitations apply | ----------none---------- |
| | Urgent care | $60 co-pay/ visit | 40% co-insurance/ visit | Network benefit level deductible does not apply. |

| Common Medical Events | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% co-insurance/ visit | 40% co-insurance/ visit | Prior Certification is required except in emergencies. |
| | Physician/surgeon fee | 20% co-insurance/ visit | 40% co-insurance/ visit | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 co-pay/ visit | 40% co-insurance/ visit | No charge for first three mental health visits with a network provider within 90 days of discharge from a network hospital for mental health inpatient care.<br>Network benefit level deductible does not apply. |
| | Inpatient services | 20% co-insurance/ visit | 40% co-insurance/ visit | Except in an emergency, Prior Certification 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.<br>Appropriate office visit charge may apply to physician office services for complications of pregnancy. |
| | Delivery professional fees | 20% co-insurance/ visit | 40% co-insurance/ visit | ----------none---------- |
| | Delivery facility fees | 20% co-insurance/ visit | 40% co-insurance/ visit | |

| Common Medical Events | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **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.<br>Prior Certification required, except for hospice care. |
| | Rehabilitation services | • 20% co-insurance/ visit for Physical, Occupational and Speech Therapy and Cardiac and Pulmonary Rehabilitation<br>• $30 co-pay/ visit for osteopathic and chiropractic manipulation | 40% co-insurance/ visit | Physical and occupational therapy limited to a combined 30 visits per contract year.<br>Osteopathic and chiropractic manipulation limited to a combined 12 visits per contract year, network benefit level deductible does not apply.<br>Speech therapy limited to a combined 30 visits per contract year.<br>Cardiac and pulmonary rehabilitation limited to a combined 30 visits per contract year. |
| | Habilitation services | • $30 co-pay/ visit for Physical, Occupational and Speech Therapy<br>• 20% co-insurance/ visit for Applied Behavior Analysis (ABA) services | 40% co-insurance/ visit | Prior Certification required for Applied Behavior Analysis (ABA).<br>Multiple charges may apply during one day of service.<br>Network benefit level deductible does not apply to flat dollar co-pays. |
| | Skilled nursing care | 20% co-insurance/ visit | 40% co-insurance/ visit | Services limited to a combined 90 days per contract year when provided by a participating provider. When services are provided by a non-participating provider, services are limited to a combined 45 days per contract year. Prior Certification required, except for hospice care. |
| | Durable medical equipment (DME) | 20% co-insurance/ visit | 40% co-insurance/ visit | Including rental, purchase or repair.<br>Prior Certification required for equipment over $1,000 and all rentals. |
| | 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 |

## 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)
- Long-term care
- 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
- Hearing aids
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Non-emergency care when traveling outside the U.S.
- 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 the number on the back of your Priority Health ID card 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.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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 número que figura en el reverso de su tarjeta de identificación de salud prioritaria.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa Tagalog, tawagan ang numero sa likod ng iyong Priority Health ID card.

Chinese (中文): 如果您需要中文帮助，请拨打优先健康身份证背面的电话.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'.

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

## 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 | $1,000 |
| Specialist co-payment | $50 |
| 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** | **$12,700** |

**In this example, Peg would pay:**

| | |
|---|---|
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Co-payments | $100 |
| Co-insurance | $2,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,660** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist co-payment | $50 |
| 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** | **$5,600** |

**In this example, Joe would pay:**

| | |
|---|---|
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Co-payments | $1,500 |
| Co-insurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$3,460** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist co-payment | $50 |
| 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** | **$2,800** |

**In this example, Mia would pay:**

| | |
|---|---|
| *Cost Sharing* | |
| Deductibles | $500 |
| Co-payments | $400 |
| Co-insurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.