WESTERN MICHIGAN HEALTH INSURANCE POOL
KENTWOOD PUBLIC SCHOOLS
SCHEDULE OF MEDICAL BENEFITS
Exclusive Provider Organization (EPO) – H.S.A. 2000/4000 Ded 100 Plan
Effective Date: January 1, 2021
Benefit Year: The 12 month period beginning each January 1 and ending each December 31.

EPO Benefits are provided or coordinated by your primary care provider ("PCP") or provided by a participating provider for office services. Services may require prior certification with the Benefit Administrator (except in a medical emergency). For a directory of Priority Health network providers, call the Customer Service Department at **616 956-1954 or 800 956-1954** or access the Find a Doctor tool on the Priority Health website at priorityhealth.com.

Prior Certification: Prior certification is required for all inpatient hospital or facility services. Non-emergency admissions must be prior certified at least five working days before admission. For emergency admissions, you must notify the Benefit Administrator as soon as reasonably possible after admission. You or your PCP must call **800 269-1260** to prior certify services. You do not need prior approval from the Benefit Administrator for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Other services requiring prior certification are:

- Home Health Care
- Skilled Nursing, Sub acute & Long-term Acute Facility Care
- Inpatient Rehabilitation Care
- Durable Medical Equipment over $1,000
- Clinical Trials (all stages) for Cancer or a Life-threatening Illness/Condition
- Transplants
- Advanced Diagnostic Imaging Services
- Prosthetic Devices over $1,000
- Certain Surgeries and Treatments

The full list of services that require prior certification is included in the Summary Plan Description (SPD) and may be updated from time to time. A current listing is also available by calling the Priority Health Customer Service Department at **616 956-1954** or **800 956-1954**. Other services may be prior certified by you or your provider to determine medical/clinical necessity before treatment. Prior certification is not a guarantee of coverage or a final determination of benefits under this plan.

If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, you or your PCP must notify our Behavioral Health Department as soon as possible for assistance. Call our Behavioral Health department at 616 464-8500 or 800 673-8043 for assistance.

Deductibles:

The deductible is the dollar amount of covered services you must incur during the plan year before benefits will be paid. Deductible amounts you pay are included in any out-of-pocket maximums. The deductible is applicable to all covered services except routine maternity care services received in your PCP's office or preventive health care services that are listed in Priority Health's Preventive Healthcare Guidelines. Charges for delivery are subject to the deductible.

If you have individual coverage, you must meet the individual deductible below. If you have more than one person in your family, you have family coverage and only the family deductible applies. The family deductible can be satisfied by only one family member or by any combination of family members.

The deductible amounts renew each plan year. This plan does not carry over any deductible amounts incurred in the prior plan year.

The deductible will include any monies paid for covered pharmacy services.

Out-of-Pocket Maximums:

The out-of-pocket maximum limits the total amount of covered expenses that you or your covered dependents will pay during a plan year. Once the applicable out-of-pocket maximum is met, all further medical and pharmacy covered services for that plan year will be paid at 100% without requirement of copayment.

If you have individual coverage, you must meet the individual out-of-pocket maximum below. If you have more than one person on your contract, you have family coverage and only the family out-of-pocket applies. The family out-of-pocket can be satisfied by only one family member or by any combination of family members.

Your out-of-pocket maximum renews each plan year.

Notwithstanding the above, the following out-of-pocket costs do not apply towards the out-of-pocket maximum: Expenses that are not covered and services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services).

The following information is provided as a summary of benefits available under your plan. This summary is not intended as a substitute for your SPD. It is not a binding contract. Limitations and exclusions apply to benefits listed below. A complete listing of covered services, limitations and exclusions is contained in the SPD and any applicable amendments to the plan.

BENEFITS	
Deductibles	$2,000 per individual; $4,000 per family per benefit year.
Benefit Percentage Rate	100% paid by the plan; 0% paid by the participant, unless otherwise noted.
Out-of-Pocket Limits (Includes deductible, coinsurance and copayment expenses.)	Total overall out-of-pocket limit of $4,000 per individual; $8,000 per family per benefit year (not to exceed $7,150 per individual per benefit year).
Preventive Health Care Services - Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available in the member center at priorityhealth.com or you may request a copy from the Customer Service Department. Priority Health's Guidelines include preventive services required by legislation. The list below also includes procedures approved by your Employer in addition to those included in the Priority Health Guidelines.	
Routine Adult Physical Exams, Screening and Counseling	Covered at 100%. Deductible does not apply.
Women's Preventive Health Care Services	Covered at 100%. Deductible does not apply.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.
Breast Magnetic Resonance Imaging (MRI Scan) (Routine and non-routine.)	Covered at 100% after deductible.
Routine Laboratory Tests, Screening and Counseling	Covered at 100%. Deductible does not apply.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%. Deductible does not apply.
Immunizations	Covered at 100%. Deductible does not apply.
Certain Drugs and Medications	Covered at 100%. Deductible does not apply.
Medical Office Services	
Primary Care Provider (PCP) Office Visit Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management visits.)	Covered at 100% after deductible.
Specialists Office Visits Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management visits.)	Covered at 100% after deductible.
Virtual Care Services (E.g. Spectrum Health or MDLive acute virtual care providers.)	Covered at 100% after deductible.
Retail Service Center Visits (Located within the United States.)	Covered at 100% after deductible for evaluation and management services.
Office Surgery	Covered at 100% after deductible.
Office Injections	Covered at 100% after deductible.
Allergy Services (Including allergy testing, evaluations and injections, including serum costs.)	Covered at 100% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office or free standing facility.)	Covered at 100% after deductible.
Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) (Performed in physician's office or freestanding facility.) Prior certification required.	Covered at 100% after deductible.
Obstetrical Services by Physician (Including prenatal and postnatal care.)	Routine prenatal and postnatal visits are covered at 100%, deductible waived under the Preventive Health Care Services benefits above. See the Hospital Services section for facility and physician benefits related to obstetrical services, including delivery and nursery services.

BENEFITS	
Other Services – (continued)	
Maternity Education Classes	Attendance at an approved maternity education program is covered at 100% after deductible.
Dietician Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	Covered at 100% after deductible.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	Covered at 100% after deductible.
Hospital Services	
Inpatient Hospital and Inpatient Longterm Acute Care Services Prior approval is required except in emergencies or for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Prior certification phone number is **800 269-1260**.	Covered at 100% after deductible.
Inpatient Professional and Surgical Charges	Covered at 100% after deductible.
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 100% after deductible.
Approved Clinical Trial Expenses (Routine expenses related to an approved clinical trial.)	Covered at 100% after deductible.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center facility charges.)	Covered at 100% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 100% after deductible.
Hospital Diagnostic Laboratory & Radiology Services	Covered at 100% after deductible.
Hospital Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) Prior certification required for outpatient services.	Covered at 100% after deductible.

BENEFITS	
Hospital Services – (continued)	
Certain Surgeries and Treatments • **Bariatric Surgery*** • **Reconstructive surgery:** blepharoplasty of upper eyelids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia • **Skin Disorder Treatments**: Scar revisions, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrheic keratoses, excision of skin tags, treatment of vitiligo and port wine stain and hemangioma treatment. • **Varicose veins treatments** • **Sleep apnea treatment procedures**	Covered at 100% after deductible. *Prior certification required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. In addition, age limitations may apply to certain surgeries and treatments. Coverage is limited to one bariatric surgery per lifetime unless medically/ clinically necessary to correct or reverse complications from a previous bariatric procedure.
Medical Emergency and Urgent Care Services	
Emergency Room Services	Covered at 100% after deductible. Reasonable and customary limitations apply for emergency room services provided by a non-participating provider.
Ambulance Services	Covered at 100% after deductible. Reasonable and customary limitations apply for emergency room services provided by a non-participating provider.
Urgent Care Facility Services	Covered at 100% after deductible.
Behavioral Health Services - Prior certification by our Behavioral Health Department is required, except in emergencies, for inpatient services as noted below: Call 616 464-8500 or 800 673-8043.	
Inpatient Mental Health & Substance Abuse Services (Including subacute residential treatment facility and partial hospitalization.) Prior certification required except in emergencies.	Covered at 100% after deductible.
Outpatient Mental Health Services Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management visits.)	Covered at 100% after deductible.
Outpatient Substance Abuse Services Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management visits.)	Covered at 100% after deductible.
Family Planning and Reproductive Services	
Infertility Counseling & Treatment (Covered for diagnosis and treatment of underlying cause only)	Covered at 50% after deductible. Prescription drugs for infertility treatment paid as shown under the prescription drug benefits shown below.
Vasectomy Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.	Covered at 100% after deductible.
Tubal Ligation/Tubal Obstructive Procedures (Included as part of the Women's Preventive Health Services benefits.)	Covered at 100%, deductible waived when performed at outpatient facilities. If received during an inpatient stay, only the services related to the tubal ligation/tubal obstructive procedures are covered at 100%, deductible waived.
Birth Control Services Medical Plan (i.e. doctor's office) (Included as part of the Women's Preventive Health Services benefits.) Includes; diaphragms, implantables, injectables, and IUD (insertion and removal), etc.	Covered at 100%, deductible waived.
Elective Abortions	Not covered.
BENEFITS	

Rehabilitative Medicine Services – Not related to Autism Treatment	
Physical and Occupational Therapy	Covered at 100% after deductible up to a benefit maximum of 50 visits per benefit year.
Speech Therapy	Covered at 100% after deductible up to a benefit maximum of 50 visits per benefit year.
Cardiac Rehabilitation and Pulmonary Rehabilitation	Covered at 100% after deductible up to a benefit maximum of 50 visits per benefit year.
Chiropractic and Spinal Manipulation (including maintenance)	Covered at 100% after deductible up to a benefit maximum of 30 visits per benefit year.
Services Related to the Treatment of Autism Spectrum Disorder (Available for children and adolescents through the age of 18 only.)	
Physical, Speech and Occupational Therapy and Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder Prior certification required for ABA.	Covered at 100% after deductible.
Other Services	
Accidental Dental Services Limited to treatment performed in the year of the accident or the following year.	Covered at 100% after deductible.
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 100% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 100% after deductible.
Temporomandibular Joint Syndrome (TMJS) Treatment	Covered at 50% after deductible.
Orthognathic Treatment	Covered at 50% after deductible.
Skilled Nursing, Inpatient Rehabilitation Facilities Treatment and Hospice Facility (Combined maximum for all services.) Prior certification required, except hospice.	Covered at 100% after deductible up to a maximum of 90 days per benefit year.
Home Health Services (Including hospice services, excluding rehabilitative medicine) Prior certification required, except hospice.	Covered at 100% after deductible.
Radiation Therapy and Chemotherapy	Covered at 100% after deductible.
Hemodialysis	Covered at 100% after deductible.
Custodial Care/Private Duty Nursing/Home Health Aides	Not covered.
Ear Care Services Covered for treatment of medical conditions and diseases of the ear only. Hearing aids are not covered.	Covered at 100% after deductible.
Eye Care Services Covered for treatment of medical conditions and diseases of the eye only. Refractive errors and vision supplies are not covered.	Covered at 100% after deductible.
Hearing Care Services	One hearing exam, one audiometric exam and one basic hearing aid per ear every 36 months. Hearing and audiometric exams covered full. Hearing aid covered in full to a maximum benefit of $1,500 for monaural and $2,542 for binaural hearing aids every 36 months. Deductible waived.

Pharmacy Benefits – Participating Pharmacies	
Prescription Drugs – Managed Formulary Includes disposable needles and syringes for diabetics. Excludes sexual dysfunction medications. Any medications provided in the Priority Health's Preventive Health Care Guidelines, including certain women's prescribed contraceptive methods are covered at 100%, copayments and deductible waived. Brand-name contraceptives (except those without a generic equivalent) are subject to applicable copayments and deductibles.	Covered prescription drugs apply to the deductible and the out-of-pocket maximum. Copayments apply after the deductible has been satisfied. Retail Pharmacy (up to 31 day supply): Tier 1 Drugs: $10 copayment Tiers 2-5 Drugs: $40 copayment Mail Service Program (up to 90 day supply) through Express-Scripts: Tier 1 Drugs: $10 copayment Tiers 2-5 Drugs: $40 copayment For information about the mail order program, visit their website at express-scripts.com. Infertility Treatment: 50% copayments for drugs used for treating infertility. (Limitations apply.)
SaveOn Specialty Drug Program	Filled through Accredo - specialty drug mail-order pharmacy. Copayments vary based on the specific drug, but will be $0 if you sign up for the SaveonSP Program. Any copayment will not apply to your out-of-pocket limit (but copayment will be $0 if you use the SaveonSP program). If you qualify for this program, you will be contacted by SaveonSP, otherwise for further details please call SaveonSP at **1-800-683-1074.**
Coverage Information	
Waiting Period Requirement	Date of hire.
Full-Time Employee	See your union contract for full-time eligibility requirements.
Dependent Children	Covered up to the end of the month in which they turn age 26. Over age 26 if mentally or physically incapacitated dependent.
Motor Vehicle Injuries	This plan shall be primary to the motor vehicle insurance policy.
Motorcycle Injuries	This plan shall be primary to the motorcycle insurance policy.

In accordance with the terms and conditions of the SPD, you are entitled to covered services when these services are:

A. Medically/clinically necessary; and
B. Not excluded in the SPD.

You will be responsible for services rendered that are beyond those prior certified as medically/clinically necessary.

If the hospital confinement extends beyond the number of certified days, the additional days will not be covered unless:

- The extension of days is medically/clinically necessary, and
- Prior certification for the extension is obtained before exceeding the number of prior certified days.

For emergency admissions, the Benefit Administrator should be notified by the end of the next business day following the admission or as soon as reasonably possible.