WHITEHALL DISTRICT SCHOOLS
SCHEDULE OF MEDICAL BENEFITS
PREFERRED PROVIDER ORGANIZATION (PPO)
HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
Effective Date: January 1, 2024
Benefit Year: The 12 month period beginning each January 1 and ending each December 31.

Network Benefits are provided by a network provider (except as otherwise provided by the PDSPD), and may require prior certification with the Benefit Administrator (except in a medical emergency). For a directory of Priority Health and Cigna Open Access 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.

Non-Network Benefits are provided by non-network providers. Services may require the satisfaction of deductibles and coinsurance amounts, and are subject to reasonable and customary charges. Some benefits must be prior certified with the Benefit Administrator (except in a medical emergency).

Prior Certification: Prior certification is required for all inpatient hospital or facility services. Providers must access the Priority Health provider portal to prior certify services. If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, your provider must notify the Behavioral Health Department as soon as possible at **616 464-8500** or **800 673-8043**. You do not need prior certification from Priority Health 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 PDSPD 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.

Deductibles:

The deductible is the dollar amount of covered services you must incur during the benefit year before benefits will be paid. The deductible is applicable to all covered services except:

- Network preventive health services that are listed in Priority Health's preventive health care guidelines.
- Network routine maternity services provided in your physician's office (deductible **will** apply to delivery, facility charges and anesthesia charges associated with the delivery).
- Certain drugs set forth in IRS Notice 2004-50. Applicable copayments will apply.
- Certain network services and supplies set forth in IRS Notice 2019-45 to treat IRS allowed chronic conditions (such as A1c testing, Lipoprotein (LDL) testing, and glucometers). Applicable copayments or coinsurance will apply. Contact the Priority Health Customer Service Department at **616 956-1954** or **800 956-1954** or visit the Priority Health website at priorityhealth.com for a list of these drugs, services and supplies.

The network and non-network deductible are calculated separately. You must meet the deductible at the network benefit level before benefits will be paid for services you seek under the network benefits. If you choose to use the non-network benefits, you must meet the deductible at the non-network benefits level before benefits will be paid for services you seek under the non-network benefits. Network deductible amounts do not apply to non-network deductible amounts, nor do non-network deductible amounts apply to network deductible amounts.

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 the family deductible below must be met. The family deductible can be satisfied by only one family member or by any combination of family members.

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

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

Notwithstanding the above, the following costs shall not apply towards the deductible: Non-covered services; services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); and any amounts paid by participants for non-network benefits that exceed reasonable and customary.

Out-of-Pocket Limits:

The out-of-pocket limit limits the total amount of covered expenses that you or your covered dependents will pay during a year. The network and out-of-network out-of-pocket limits are calculated separately. Once the applicable out-of-pocket limit for the network benefits level is met, all further medical and pharmacy covered services for that benefit year for network benefits will be paid at 100% of network's contracted rate. Once the applicable out-of-pocket for the non-network benefits level is met, all further medical covered services for that benefit year for non-network benefits will be paid at 100% of the lesser of billed charges or reasonable and customary charges. Network out-of-pocket amounts do not apply to non-network out-of-pocket amounts, nor do non-network out-of-pocket amounts apply to network out-of-pocket amounts.

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

Notwithstanding the above, the following out-of-pocket costs do not apply towards the out-of-pocket limit: Expenses for non-covered services, services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); and costs paid by participants to provider for non-network benefits that exceed reasonable and customary.

The following information is provided as a summary of benefits available under your plan. This summary is not intended as a substitute for your Plan Document and Summary Plan Description (PDSPD). 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 PDSPD and any applicable amendments to the Plan.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Deductibles	$2,000 per individual; $4,000 per family per benefit year.	$3,000 per individual; $6,000 per family per benefit year.
Benefit Percentage Rate	80% paid by the plan; 20% paid by the participant, unless otherwise noted.	60% paid by the plan; 40% paid by the participant, unless otherwise noted.
Out-of-Pocket Limits (Includes deductible, coinsurance and copayment expenses.)	$3,000 per individual; $6,000 per family per benefit year.	$6,000 per individual; $12,000 per family per benefit year.
Preventive Health Care Services - Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available on 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.	Not covered.
Women's Preventive Health Care Services	Covered at 100%. Deductible does not apply.	Not covered.
Routine Laboratory Tests, Screening and Counseling (Includes additional select lab procedures, ekg and chest x-ray.)	Covered at 100%. Deductible does not apply.	Not covered.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.	Not covered.
Breast Magnetic Resonance Imaging (MRI Scan) (Routine and non-routine.)	Covered at 100% after deductible.	Not covered.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%. Deductible does not apply.	Not covered.
Immunizations	Covered at 100%. Deductible does not apply.	Not covered.
Certain Drugs and Medications	Covered at 100%. Deductible does not apply.	Not covered.
Diabetic Care Services Program Provided by Virta Health only.	Covered at 100%. Deductible does not apply.	Not available.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Office/Home Services		
Office/Home Visits and Consultations Face-to-face visits. (Includes visits *not* listed in Priority Health's Preventive Health Care Guidelines or routine maternity services.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Virtual Care Services (Telehealth includes telephonic and telemedicine.) (Including medication management visits.)	Covered at 100% after deductible.	Covered at 60% after deductible.
Retail Health Clinic Visits (Located within the United States.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Office Surgery	Covered at 80% after deductible.	Covered at 60% after deductible.
Office Injections	Covered at 80% after deductible.	Covered at 60% after deductible.
Allergy Services (Including allergy testing and injections, including serum costs.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office or freestanding facility.)	Covered at 80% after deductible.	Covered at 60% after deductible. **Genetic Testing Services are not covered.**
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 80% after deductible.	Covered at 60% after deductible.
Maternity Services	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 delivery and nursery services.	Covered at 60% after deductible.
Maternity Education Classes	Attendance at an approved maternity education program is covered at 100% after deductible.	Not covered.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	Covered at 80% after deductible.	Not covered.
Hospital Services		
Inpatient Hospital and Inpatient Longterm Acute Care Services Prior certification 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.	Covered at 80% after deductible.	Covered at 60% after deductible.
Inpatient Professional and Surgical Charges *Evaluation and Management for Inpatient and Observation services covered at the Network rate when at a network facility.	Covered at 80% after deductible.	Covered at 60% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Hospital Services (continued)		
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 80% after deductible.	Covered at 60% after deductible.
Approved Clinical Trial Expenses (Routine expenses related to an approved clinical trial.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center facility charges.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 80% after deductible.	Covered at 60% after deductible.
Maternity Services in Hospital (Delivery, facility and anesthesia services.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Hospital Diagnostic Laboratory & Radiology Services	Covered at 80% after deductible.	Covered at 60% after deductible. **Genetic Testing Services are not covered.**
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 80% after deductible.	Covered at 60% after deductible.
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 80% 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.	Covered at 60% 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.
If the services of a surgical assistant are required for a surgical procedure, the non-network covered expenses will be the lesser of: (1) the amount charged by the assistant; or (2) 20% of the amount allowable to the physician who performed the surgery.		
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered at 80% after deductible.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
Ambulance Services	Covered at 80% after deductible.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	Covered at 80% after deductible.	Covered at 60% 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 Use Disorder Services (Including subacute residential treatment and partial hospitalization.) Prior certification required except in emergencies.	Covered at 80% after deductible.	Covered at 60% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Behavioral Health Services (continued)		
Outpatient Mental Health Services Face-to-face visits.	The first three visits (within 90 days of discharge) from a network hospital for mental health inpatient care are covered at 100% after deductible. Visits thereafter apply as noted below. Covered at 80% after deductible.	Covered at 60% after deductible.
Outpatient Substance Use Disorder Services Face-to-face visits.	Covered at 80% after deductible.	Covered at 60% after deductible.
Family Planning and Reproductive Services		
Infertility Counseling & Treatment (Covered for diagnosis and treatment of underlying cause only.)	Covered at 50% after deductible.	Covered at 50% after deductible.
Vasectomy Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.	Covered at 80% after deductible.	Not covered.
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 procedure are covered in full, deductible waived.	Not covered.
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.	Not covered.
Elective Abortions	Not covered.	Not covered.
Rehabilitative Medicine Services – Not related to Autism Treatment.		
Physical, Speech and Occupational Therapy (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a benefit maximum of 40 visits per benefit year.	Covered at 60% after deductible up to a benefit maximum of 40 visits per benefit year.
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a benefit maximum of 40 visits per benefit year.	Covered at 60% after deductible up to a benefit maximum of 40 visits per benefit year.
Chiropractic and Osteopathic Manipulation Services (Includes maintenance care.) (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a benefit maximum of 30 visits per benefit year.	Covered at 60% after deductible up to a benefit maximum of 30 visits per benefit year.
Services Related to the Treatment of Autism Spectrum Disorder		
Physical, Occupational and Speech Therapy; Applied Behavior Analysis (ABA). Prior certification is required for ABA.	Covered at 80% after deductible.	Covered at 60% after deductible.
Other Services		
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 50% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 50% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (Continued.)		
Temporomandibular Joint Syndrome (TMJS) Treatment	Covered at 50% after deductible.	Covered at 50% after deductible.
Orthognathic Treatment	Covered at 50% after deductible.	Covered at 50% after deductible.
Non-Hospital Facility Services – Including skilled nursing care services received in a: • Skilled Nursing Care Facility • Subacute Facility • Inpatient Rehabilitation Facilities Treatment • Hospice Facilities Prior certification required, except hospice. (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a maximum of 45 days per benefit year after deductible.	Covered at 60% after deductible up to a maximum of 45 days per benefit year after deductible.
Home Health Services and Infusion Therapy (Including hospice services, excluding rehabilitative medicine.) Prior certification required, except hospice.	Covered at 80% after deductible.	Covered at 60% 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 applies to all benefits.	Not covered.
Private Duty Nursing (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a maximum of 90 days per benefit year after deductible.	Covered at 60% after deductible up to a maximum of 90 days per benefit year after deductible.
Pharmacy Benefits – Participating Pharmacies		
Prescription Drugs – Managed Formulary Includes disposable needles and syringes for diabetics, infertility medications. CGM available at pharmacy only, covered at 100%. Exclude certain sexual dysfunction medications. Any medications provided in 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 deductible and copayments. Expenses for non-covered prescription drugs will not be applied towards your deductible or out of pocket maximum.	Covered prescription drugs apply to the plan deductible and out-of-pocket maximum. Copayments apply after satisfaction of the deductible. <u>Retail Pharmacy (up to 31 days):</u> Tier 1 Drugs: $10 copayment Tiers 2&4 Drugs: $40 copayment Tiers 3&5 Drugs: $80 copayment <u>Infertility Drugs</u>: 50% copayment <u>Mail Service Program (90 days):</u> Tier 1 Drugs: $20 copayment Tier 2 Drugs: $80 copayment Tier 3 Drugs: $160 copayment For information about the mail order program, visit their website at <u>express-scripts.com</u>. Certain drugs set forth in IRS Notice 2004-50 and Notice 2019-45 shall be covered prior to satisfying your deductible. Applicable copayments listed above will 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**.
Pursuant to IRS Publication 969 – *Health Savings Accounts and Other Tax-Favored Health Plans* – participation in a prescription drug plan that provides benefits before the deductible is met makes the plan disqualifying coverage since it's not a high deductible health plan, and may make you ineligible to contribute tax-free dollars to a health savings account due to your HSA losing its tax exemption. Contributions made to an HSA that lost its tax exemption, either on behalf of an individual, or by an individual who is not eligible for an HSA under IRS rules will be treated as taxable income. Please consult your tax advisor.	
Coverage Information	
Waiting Period Requirement	Date of hire.
Hourly Employee Requirements	30 hours worked per week.
Dependent Children	Covered up to the end of the month in which they turn age 26. Age 26 and older covered 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 PDSPD, you are entitled to covered services when these services are:

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

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 prior 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.

Coverage maximums up to a certain number of days or visits per benefit year are reached by combining either network or non-network benefits up to the limit for one or the other but not both. (Example: If the network benefit is for 60 visits and the non-network benefit is for 60 visits, the maximum benefit is 60 visits, not 120 visits.)