WESTERN MICHIGAN HEALTH INSURANCE POOL –
MECOSTA OSCEOLA ISD
SCHEDULE OF MEDICAL BENEFITS
Point of Service (POS) Plan
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.

Preferred Benefits are provided by your primary care provider (PCP) or by a participating provider for office services. Services may require prior certification with the Benefit Administrator when prior certification is considered necessary (except in a medical emergency). Referrals by your PCP to a non-participating provider must also be prior certified by Priority Health. 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.

Alternate Benefits are not coordinated through your PCP, and are provided by non-participating providers. If you have not selected a PCP, only Alternate Benefits are available. Services may require the satisfaction of deductibles, coinsurance, and are subject to reasonable and customary charges. Some benefits must be prior certified with the Benefit Administrator when prior certification is considered necessary (except in a medical emergency).

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 certification 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

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 benefit 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 and provided by a participating provider. Charges for delivery are subject to the deductible.

Preferred Benefits deductible amounts do not apply to Alternate Benefits deductible amounts, nor do Alternate Benefits deductible amounts apply to Preferred Benefits 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 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 benefit year. The preferred deductible will include any monies paid for covered pharmacy services.

Notwithstanding the above, the following costs do not apply towards the deductible: Services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-covered services).

Out-of-Pocket Limits:

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

If you have individual coverage, when calculating your out-of-pocket, the plan will include all copayments and deductibles paid toward covered services during a benefit year. If you have family coverage, the plan will include all copayments and deductibles you and your family paid collectively toward covered services during a benefit year.

Your out-of-pocket limit renews each benefit year. The preferred out-of-pocket limit will include any monies paid for covered pharmacy services.

Notwithstanding the above, the following out-of-pocket costs do not apply toward the out-of-pocket limit: Services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); and costs paid by participant for alternate 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 SPD. It is not a binding contract. Limitations and exclusions apply to benefits SPD and any applicable amendments to the Plan.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Deductibles	$1,600 per individual; and $3,200 per family each benefit year.	$3,200 per individual; and $6,400 per family each benefit year.
Benefit Percentage Rate	90% paid by the plan; 10% paid by the participant, unless otherwise noted.	70% paid by the plan; 30% paid by the participant, unless otherwise noted.
Out-of-Pocket Limits ***Please note the deductible and copayments do apply to the out-of-pocket maximum.***	$2,600 ($1,600 deductible and $1,000 for coinsurance and copays) per individual; and $5,200 ($3,200 deductible and $2,000 for coinsurance and copays) per family per benefit year.	$5,200 ($3,200 deductible and $2,000 for coinsurance and copays) per individual; and $10,400 ($6,400 deductible and $4,000 for coinsurance and copays) per family 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.	Covered at 70% after deductible.
Women's Preventive Health Care Services	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
Breast Magnetic Resonance Imaging (MRI Scan) (Routine and non-routine.)	Covered at 100% after deductible.	Covered at 70% after deductible.
Routine Laboratory Tests, Screening and Counseling	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
Immunizations	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
Certain Drugs and Medications	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
Diabetic Care Services Program Provided by Virta Health only.	Covered at 100%. Deductible does not apply.	Not covered.
Medical Office/Home Services		
Primary Care Physician Office Visits Face-to-face. (Including medication management visits.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Specialists Office Visits Face-to-face.	Covered at 90% after deductible.	Covered at 70% after deductible.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Medical Office/Home Services (continued)		
Virtual Care Services (Telehealth includes telephonic and telemedicine.) (Including medication management visits.)	Covered at 100% after deductible.	Covered at 70% after deductible.
Retail Service Center Visits (Located within the United States.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Office Surgery	Covered at 90% after deductible.	Covered at 70% after deductible.
Office Injections	Covered at 90% after deductible.	Covered at 70% after deductible.
Allergy Services (Including allergy testing and injections, including serum costs.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office or freestanding facility.)	Covered at 90% after deductible.	Covered at 70% 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 90% after deductible.	Covered at 70% 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 delivery and nursery services.	Covered at 70% after deductible.
Prenatal Classes	Covered at 90% after deductible.	Covered at 70% after deductible.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	Covered at 90% 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 90% after deductible.	Covered at 70% after deductible.
Obstetrical Services in Hospital (Delivery, facility and anesthesia services.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Inpatient Professional Charges	Covered at 90% after deductible.	Covered at 70% after deductible.
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 90% after deductible.	Covered at 70% after deductible.
Approved Clinical Trial Expenses (Routine expenses related to an approved clinical trial.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Outpatient Hospital Facility Services	Covered at 90% after deductible.	Covered at 70% after deductible.
Outpatient Hospital Professional Charges	Covered at 90% after deductible.	Covered at 70% after deductible.
Hospital Diagnostic Laboratory & Radiology Services	Covered at 90% after deductible.	Covered at 70% after deductible.
Hospital Advanced Diagnostic Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies. Prior certification required.	Covered at 90% after deductible.	Covered at 70% after deductible.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Hospital Services (continued)		
Certain Surgeries and Treatments (Physician fees only) • **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 90% after deductible. In addition, age limitations may apply to certain surgeries and treatments. **Prior certification required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless medically/ clinically necessary to correct or reverse complications from a previous bariatric procedure.	Covered at 70% after deductible. In addition, age limitations may apply to certain surgeries and treatments. **Prior certification required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless medically/ clinically necessary to correct or reverse complications from a previous bariatric procedure.
If the services of a surgical assistant are required for a surgical procedure, the Alternate 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 90% after deductible.	Paid at the Preferred Benefit Level. Reasonable and customary limitations apply.
Ambulance Services	Covered at 90% after deductible.	Paid at the Preferred Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	Covered at 90% after deductible.	Covered at 70% 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 facility and partial hospitalization) Prior certification required except in emergencies.	Covered at 90% after deductible.	Covered at 70% after deductible.
Outpatient Mental Health Services Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management 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, covered at 90% after deductible.	Covered at 70% after deductible.
Outpatient Substance Use Disorder Services Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management visits.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Family Planning and Reproductive Services		
Infertility Counseling & Treatment Covered for diagnosis and treatment of underlying cause only. Limitations and exclusions apply.	Covered at 50% after deductible.	Not covered.
Vasectomy Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.	Covered at 90% after deductible.	Not covered.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Family Planning and Reproductive Services (continued)		
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 at 100%. Deductible does not apply.	Covered at 70% after deductible.
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 does not apply.	Covered at 70% after deductible.
Rehabilitative Medicine Services		
Physical and Occupational Therapy (Combined Preferred/Alternate Benefit.)	Covered at 90% after deductible up to a combined benefit maximum of 40 visits per plan year.	Covered at 50% after deductible up to a combined benefit maximum of 40 visits per plan year.
Speech Therapy (Combined Preferred/Alternate Benefit.)	Covered at 90% after deductible up to a benefit maximum of 40 visits per plan year.	Covered at 50% after deductible up to a benefit maximum of 40 visits per plan year.
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Preferred/Alternate Benefit.)	Covered at 90% after deductible up to a combined benefit maximum of 40 visits per plan year.	Covered at 50% after deductible up to a benefit maximum of 40 visits per plan year.
Chiropractic and Spinal Manipulation (including maintenance) (Combined Preferred/Alternate Benefit.)	Covered at 90% after deductible up to a benefit maximum of 30 visits per plan year.	Covered at 50% after deductible up to a combined benefit maximum of 30 visits per plan year.
Services Related to the Treatment of Autism Spectrum Disorder		
Physical, Speech and Occupational Therapy and Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder Prior certification required for ABA.	Covered at 90% after deductible.	Covered at 50% after deductible.
Pharmacy Benefits – Participating Pharmacies		
Prescription Drugs – Managed Formulary Includes disposable needles and syringes for diabetics. CGM available at pharmacy only, covered at 100%. Excludes select 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%, deductible and copayment waived. Brand-name contraceptives (except those without a generic equivalent) are subject to applicable copayments.	Covered prescription drugs apply to the deductible and the out-of-pocket limit. Pharmacy: Tier 1 Drugs: $10 copayment Tiers 2-5 Drugs: $40 copayment Mail Service Program (up to 90 days): Tier 1 Drugs: $20 copayment Tiers 2-3 Drugs: $80 copayment Infertility Treatment: 50% copay 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**.	

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.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Other Services (continued)		
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 70% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 70% after deductible.
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.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facilities (Combined Preferred/Alternate Benefit.) Prior certification required, except for hospice.	Covered at 90% after deductible up to 90 days per benefit year.	Covered at 70% after deductible up to 45 days per benefit year.
Home Health Services Prior certification required, except for hospice.	Covered at 90% after deductible.	Covered at 70% after deductible.
Radiation Therapy and Chemotherapy	Covered at 90% after deductible.	Covered at 70% after deductible.
Hemodialysis	Covered at 90% after deductible.	Covered at 70% after deductible.
Custodial Care/Private Duty Nursing	Not covered.	Not covered.
Ear Care Services Covered for treatment of medical conditions and diseases of the ear only. Hearing aids are not covered.	Covered at 90% after deductible.	Covered at 70% 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 90% after deductible.	Covered at 70% 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.
Coverage Information		
Waiting Period Requirement	Date of hire.	
Employee Hourly Requirement	29 hours worked per week.	
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 prior certified days, the additional days will not be covered unless:

The extension of days if 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.