KELLOGGSVILLE PUBLIC SCHOOLS
SCHEDULE OF MEDICAL BENEFITS
Exclusive Provider Organization (EPO) - High Deductible Health Plan (HDHP)
Out-of-Area Dependent Children Benefit Plan – LEVEL PHKL1
Effective Date: January 1, 2025
Benefit Year: The 12-month period beginning each January 1 and ending each December 31.

Out-of-Area Dependent Children Benefits. This Out-of-Area Dependent Children Benefit Plan schedule is designed for a covered dependent child or children who live outside of Priority Health's Service Area and within the United States. (Note: Dependent children who are living outside of the United States are covered for medical emergencies and urgent care services only.)

- If you are a covered dependent child living within the Priority Health service area, you are covered at the IN AREA (EPO Plan) benefit level shown below. Information regarding the Priority Health service area is available by contacting Customer Service or access the Find a Doctor tool on the Priority Health website at prioritythealth.com.
- If you are a covered dependent child living outside the service area but within the United States and services are provided by a Cigna Open Access provider located outside the Service Area but within the United States, services are covered at the IN AREA (EPO Plan) benefit level shown below.
- If you are a covered dependent child living outside the Priority Health service area but within the United States, services are covered at the OUT OF AREA benefits level shown below when services are provided by a non-participating provider. Services are subject to reasonable and customary charges.

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 participating 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 prioritythealth.com.

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. 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
- Certain Surgeries and Treatments

The full list of services that require prior certification is included in the Plan Document and Summary Plan Description (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.

If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, your PCP must notify the Behavioral Health Department as soon as possible 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. The deductible is applicable to all covered services except:

- Preventive health services that are listed in Priority Health's preventive health care guidelines.
- Routine maternity services provided in your physician's office (deductible **will** apply to delivery, facility charges and anesthesia charges associated with the delivery).

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. This plan does not carry over any deductible amounts incurred in the prior benefit 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 benefit year. Once the applicable out-of-pocket maximum 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, 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 benefit year.

Notwithstanding the above, the following out-of-pocket costs do not apply towards the out-o

f-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 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	IN AREA	OUT OF AREA
Deductibles	$1,650 per individual; $3,300 per family per 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 (Includes deductible, coinsurance and copayment expenses.)	$2,650 per individual; $5,300 per family per benefit year.	
BENEFITS		
Preventive Health Care Services - Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available online 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.	Not covered out of area.
Women's Preventive Health Care Services	Covered at 100%. Deductible does not apply.	Not covered out of area.
Routine Laboratory Tests, Screening and Counseling	Covered at 100%. Deductible does not apply.	Not covered out of area.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.	Not covered out of area.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%. Deductible does not apply.	Not covered out of area.
Immunizations	Covered at 100%. Deductible does not apply.	Not covered out of area.
Certain Drugs and Medications	Covered at 100%. Deductible does not apply.	Not covered out of area.
Diabetic Care Services Program Provided by Virta Health only.	Covered at 100%. Deductible does not apply.	Not covered.

BENEFITS	IN AREA	OUT OF AREA
Medical Office/Home Services		
Your Primary Care Provider (PCP) - Office Visit (Your selected or assigned PCP and/or PCP Practice.) (Face-to-face visit.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Virtual Care Services (Telehealth includes telephonic and telemedicine.) (Including medication management visits.)	Covered at 100% after deductible.	Covered at 70% after deductible.
Retail Health Clinic Visits (Located within the United States)	Covered at 90% after deductible.	Covered at 70% after deductible.
Specialists and Providers Other Than Your PCP and/or PCP Practice - Office Visits (Face-to-face visit.)	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 Injections	Covered at 90% after deductible.	Covered at 70% after deductible.
Allergy Testing and Serum	Covered at 90% after deductible.	Covered at 70% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office or free standing 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 obstetrical services, including delivery and nursery services.	Covered at 70% after deductible.
Maternity Education Classes	Attendance at an approved maternity education program is covered at 100% after deductible.	Not covered out of area.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	Covered at 90% after deductible.	Not covered out of area.
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. Inpatient hospital services out of Priority Health's service area approved by your PCP and Priority Health and emergent inpatient hospital services will be covered at the in-area benefit.
Inpatient Professional and Surgical 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 approved clinical trial.)	Covered at 90% after deductible.	Covered at 70% after deductible.

BENEFITS	IN AREA	OUT OF AREA
Hospital Services (continued)		
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center facility charges.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 90% after deductible.	Covered at 70% after deductible.
Maternity Services in Hospital (Delivery, facility and anesthesia services.)	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 for outpatient services.	Covered at 90% after deductible.	Covered at 70% 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 90% after deductible. *Prior certification required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Additional limitations may apply. Coverage is limited to one bariatric surgery per lifetime unless medically/ clinically necessary.	Covered at 70% after deductible. *Prior certification required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Additional limitations may apply. Coverage is limited to one bariatric surgery per lifetime unless medically/ clinically necessary.
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered at 90% after deductible. Reasonable and customary limitations apply for services provided by a non-participating provider.	Initial visit covered at the In-Area Benefit. Coverage includes one follow-up visit within 60 days after an emergency room visit. Covered at 70% after deductible for ongoing treatment after emergent care.
Ambulance Services	Covered at 90% after deductible. Reasonable and customary limitations apply for services provided by a non-participating provider.	Covered at the In-Area Benefit. Reasonable and customary limitations apply.
Urgent Care Facility Services	Covered at 90% after deductible.	Initial visit covered at the In-Area Benefit. Covered at 70% after deductible for ongoing treatment after urgent care services.

BENEFITS	IN AREA	OUT OF AREA
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 visit)	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 90% after deductible.	Covered at 70% after deductible.
Outpatient Substance Use Disorder Services (Face-to-face visit)	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.)	Covered at 50% after deductible. Prescription drugs for infertility treatment paid as shown under the prescription drug benefits shown below.	Not covered out of area.
Vasectomy	Covered at 90% after deductible.	Not covered out of area.
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.	Not covered out of area.
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 out of area.
Elective Abortions	Not covered.	Not covered.
Rehabilitative Medicine Services – Not related to Autism Treatment		
Physical and Occupational Therapy	Covered at 90% after deductible up to a benefit maximum of 60 visits per benefit year.	Covered at 50% after deductible up to a benefit maximum of 60 visits per benefit year.
Speech Therapy	Covered at 90% after deductible up to a benefit maximum of 60 visits per benefit year.	Covered at 50% after deductible up to a benefit maximum of 60 visits per benefit year.
Cardiac Rehabilitation and Pulmonary Rehabilitation	Covered at 90% after deductible up to a benefit maximum of 60 visits per benefit year.	Covered at 50% after deductible up to a benefit maximum of 60 visits per benefit year.
Chiropractic and Osteopathic Manipulation Services (Includes maintenance care.)	Covered at 90% after deductible up to a benefit maximum of 30 visits per benefit year.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.

BENEFITS	IN AREA	OUT OF AREA
Habilitative Services Related to the Treatment of Autism Spectrum Disorder		
Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder	Covered at 90% after deductible.	Covered at 50% after deductible.
Speech Therapy for the treatment of Autism Spectrum Disorder	Covered at 90% after deductible.	Covered at 50% after deductible.
Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder Prior certification required.	Covered at 90% after deductible.	Covered at 50% after deductible.
Other Services		
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 100% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 100% after deductible.
Temporomandibular Joint Dysfunction or Syndrome Treatment	Covered at 50% after deductible.	Not covered out of area.
Orthognathic Treatment	Covered at 50% after deductible.	Not covered out of area.
Non-Hospital Facility Services – Including skilled nursing care services received in a: • Skilled Nursing Care Facility • Subacute Facility • Inpatient Rehabilitation Facilities Treatment • Hospice Facilities (Combined maximum for all services.) Prior certification required, except Hospice Facilities.	Covered at 90% after deductible up to a maximum of 90 days per benefit year.	Covered at 70% after deductible up to a maximum of 90 days per benefit year.
Home Health Services and Infusion Therapy (Including hospice services, excluding rehabilitative medicine.) Prior certification required, except hospice services.	Covered at 90% after deductible.	Covered at 70% after deductible.
Custodial Care/Private Duty Nursing/Home Health Aides	Not covered.	Not covered.
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.

Pharmacy Benefits – Participating Pharmacies	
Prescription Drugs – Managed Formulary Includes disposable needles and syringes for diabetics and infertility medications. CGM available at pharmacy only, covered at 100%. Excludes select 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 waived. Brand-name contraceptives (except those without a generic equivalent) are subject to applicable 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 deductible and the out-of-pocket maximum. Copayments apply after the deductible has been satisfied. Retail Pharmacy (up to 31 days): Tier 1 Drugs: $10 copayment Tier 2 - 5 Drugs: $40 copayment Infertility Drugs: 50% copayment Mail Service Program (90 days): Tier 1 Drugs: $20 copayment Tier 2 - 3 Drugs: $80 copayment For information about the mail order program, visit their website at express-scripts.com.
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	
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	Plan shall pay primary to any motor vehicle insurance.
Motorcycle Injuries	Plan shall pay primary to any motorcycle insurance.

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 those services that are beyond those approved, beyond the benefit maximums or excluded from coverage.

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.