WESTERN MICHIGAN HEALTH INSURANCE POOL – MANISTEE AREA PUBLIC SCHOOLS
SCHEDULE OF MEDICAL BENEFITS
Point of Service (POS) Plan
Effective Date: October 1, 2023
Benefit Year: The initial benefit period shall be October 1, 2023 through December 31, 2023; thereafter, 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 or Cigna Open Access 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 priorityhealth.com.

Alternate Benefits are not coordinated through your PCP, and are provided by non-participating providers. 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. 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 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 provider must notify the Behavioral Health Department as soon as possible at **616 464-8500 or 800 673-8043**.

Preferred benefits deductible, coinsurance and out-of-pocket amounts do not apply to Alternate Benefits deductible, coinsurance and out-of-pocket amounts, nor do Alternate Benefits deductible, coinsurance and out-of-pocket amounts apply to Preferred Benefits deductible, coinsurance and out-of-pocket amounts.

Carry-over: Deductible amounts met in the last three months of the benefit year will be applied towards the deductible and amount for the next benefit year.

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	PREFERRED BENEFITS	ALTERNATE BENEFITS
Deductibles	$250 per individual; and $500 per family per benefit year.	$500 per individual; and $1,000 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.
Coinsurance Maximums (Does not include deductible or copayments.)	$1,500 per individual; $3,000 per family per benefit year.	$3,000 per individual; $6,000 per family per benefit year.
Out-of-Pocket Limit (Includes deductible, coinsurance and copayment expenses.)	$5,000 per individual; $10,000 per family per benefit year.	$10,000 per individual; $20,000 per family per benefit year.

BENEFITS	PREFERRED BENEFIT	ALTERNATE BENEFIT
Preventive Health Care Services - Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available in the member center at prioritythealth.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 (Includes routine pre-and postnatal services for employees/covered spouses and routine prenatal care services required by the Patient Protection and Affordable Care Act (PPACA) for dependent children.)	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
Routine Laboratory Tests, Screening and Counseling	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%. 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		
Your Primary Care Provider (PCP) (Your selected or assigned PCP and/or PCP Practice.) Face-to-face visits.	$15 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Virtual Care Services (Telehealth includes telephonic and telemedicine.) (Including medication management visits.)	$0 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Retail Health Clinic Visits (Located within the United States.)	$75 copayment per visit for evaluation and management services. Deductible does not apply.	$75 copayment per visit for reasonable and customary charges for evaluation and management services. Deductible does not apply.
Specialists and Providers Other Than Your PCP and/or PCP Practice Face-to-face visits.	$35 copayment per visit. Deductible does not apply.	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 100%. Deductible does not apply.	Covered at 70% after deductible.
Office Diagnostic Radiology and Lab Services	Covered at 90% after deductible.	Covered at 70% 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.	$150 copayment per service. Deductible does not apply.	Covered at 70% after deductible.
Obstetrical Services by Physician (Including prenatal and postnatal care.) **(Dependent children maternity services benefits are limited to routine prenatal care services only required by PPACA.)**	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.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Medical Office/Home Services (Continued.)		
Maternity Education Classes	Attendance at an approved maternity education program is covered at 100%. Deductible does not apply.	Not covered.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	$35 copayment. Deductible does not apply.	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.
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 an approved clinical trial.)	Covered at 90% after deductible.	Covered at 70% after deductible.
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.) **Dependent maternity services expenses are not covered.**	Covered at 90% after deductible.	Covered at 70% after deductible.
Hospital and Freestanding Facility Diagnostic Laboratory & Radiology Services	Covered at 90% after deductible.	Covered at 70% 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.	$150 copayment per service. Deductible does not apply.	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. 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 70% 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 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.		

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Medical Emergency and Urgent Care Services		
Emergency Room Services	$250 copayment per visit. Deductible does not apply.	Paid at the Preferred Benefit Level. Reasonable and customary limitations apply.
Note: If you are admitted for hospital inpatient care or hospital observation care from the emergency room, your emergency room charges will be paid under the hospital services benefits and the emergency room services copayment does not apply.		
Ambulance Services	$250 copayment. Deductible does not apply.	Paid at the Preferred Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	$75 copayment per visit. Deductible does not apply.	$75 copayment per visit. Deductible does not apply.
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 visits.)	The first three visits (within 90 days of discharge) from a network hospital for mental health inpatient care are covered at 100%, deductible does not apply. Visits thereafter apply as noted below. $15 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Outpatient Substance Use Disorder Services Face-to-face visits.)	$15 copayment per visit. Deductible does not apply.	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.	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 100% when performed in physician's office. Deductible does not apply. Covered at 90% after deductible when performed in an inpatient or outpatient facility.	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.	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 waived.	Covered at 70% after deductible.
Elective Abortions	Not covered.	Not covered.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Rehabilitative Medicine Services		
Physical and Occupational Therapy (Including osteopathic and chiropractic manipulation.) (Includes maintenance care.) (Combined Preferred/Alternate Benefit.)	$35 copayment per visit up to a benefit maximum of 30 visits per benefit year. Deductible does not apply.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
Speech Therapy (Combined Preferred/Alternate Benefit.)	$35 copayment per visit up to a benefit maximum of 30 visits per benefit year. Deductible does not apply.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Preferred/Alternate Benefit.)	$35 copayment per visit up to a benefit maximum of 30 visits per benefit year. Deductible does not apply.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
Habilitation Services for the Treatment of Autism Spectrum Disorder		
Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder	$15 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Speech Therapy for the Treatment of Autism Spectrum Disorder	$15 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder Prior certification required.	Covered at 90% after deductible.	Covered at 70% after deductible.
Habilitation Services (not related to Autism Spectrum Disorder)		
Physical and Occupational Therapy (Combined Preferred/Alternate Benefit.)	$35 copayment per visit up to a benefit maximum of 30 visits per benefit year. Deductible does not apply.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
Speech Therapy (Combined Preferred/Alternate Benefit.)	$35 copayment per visit up to a benefit maximum of 30 visits per benefit year. Deductible does not apply.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
Other Services		
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 50% after deductible.	Covered at 50% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 50% after deductible.	Covered at 50% 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.
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 facilities. (Combined Preferred/Alternate Benefit.)	Covered at 90% after deductible up to 45 days per benefit year.	Covered at 70% after deductible up to 45 days per benefit year.
Home Health Services (Including hospice services, excluding rehabilitative medicine.) Prior certification required, except for hospice.	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
Custodial Care/Private Duty Nursing/Home Health Aides	Not covered.	

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Other Services (Continued.)		
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.	Not covered.
Pharmacy Benefits – Participating Pharmacies		
Prescription Drugs – Managed Formulary Includes disposable needles and syringes for diabetics and infertility medication. 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.	Deductible does not apply. Retail Pharmacy (up to 31 days): Tier 1 Drugs: $5 copayment Tier 2 Drugs: $40 copayment Tier 3 Drugs: $80 copayment Tier 4 Drugs: 20% copayment to a maximum of $150 per fill. Tier 5 Drugs: 20% copayment to a maximum of $250 per fill. Infertility Drugs: 50% copayment Mail Service Program (90 days): Tier 1 Drugs: $10 copayment Tier 2 Drugs: $80 copayment Tier 3 Drugs: $160 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.**	
Medical Plan Pharmacy Services		
Drugs Requiring Administration by a Health Professional (Injectable and infusible drugs requiring administration by a health professional in a medical office, home or outpatient facility.) Prior certification required.	Deductible does not apply. Preferred Specialty Drugs: 20% copayment up to a maximum per injection or infusion of $150. Non-Preferred Specialty Drugs: 20% copayment up to a maximum per injection or infusion of $250. Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.	
Coverage Information		
Waiting Period Requirement	Date of hire.	
Full-Time Employee	30 hours worked per week.	
Part-Time Employee	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.

The amount used to meet the individual deductible for each member of a family is also used in meeting the family deductible. The "coinsurance maximum" applies to certain inpatient and outpatient hospital services and non-hospital facility services. The coinsurance maximum limits the amount of coinsurance for covered services that you or your covered dependents will pay during a benefit year, except as described below. If the individual coinsurance maximum is reached during a benefit year, the benefit percentage is 100% of covered expenses incurred by that person for the rest of the benefit year. If the family coinsurance maximum is reached during a benefit year, the benefit percentage is 100% of covered expenses for the employee and all of the employee's covered dependents for the rest of the benefit year. Amounts you pay for any of the following will not apply toward the coinsurance maximum. (Your cost sharing (copayments or coinsurance) applies to these services even after the coinsurance maximum has been reached.)

- Any flat dollar copayments;
- Any copayments for specialty drugs;
- Deductibles;
- Durable medical equipment (DME);
- Prosthetic and orthotic/support devices;
- Orthognathic surgery;
- Temporomandibular joint dysfunction or syndrome; and
- Family planning/infertility services; and
- Preventive health care services.

Additionally, your coinsurance maximum will not take into account:

- any monies you paid for non-covered services; and
- any monies you paid for covered services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-covered services; and
- any monies you paid to providers for alternate benefits that exceed reasonable and customary.

The "out-of-pocket limit" is the total amount of deductible (if any), coinsurance and copayments for covered services, including covered prescription drug services, that you will pay during the benefit year, except as described below. If the individual annual out-of-pocket limit is reached during a benefit year, the plan will pay 100% of covered expenses incurred by that person for the rest of the benefit year. If the family out-of-pocket limit is reached during a benefit year, the plan will pay 100% of covered expenses for the employee and all of the employee's covered dependents for the rest of the benefit year. Amounts paid for any of the following will not apply toward the out-of-pocket limit and you will be responsible for the following expenses even after the out-of-pocket limit has been reached:

- any monies you paid to providers for alternate benefits that exceed reasonable and customary; and
- any monies you paid for non-covered services; and
- any monies you paid for covered services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-covered services.

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