KENT ISD
SCHEDULE OF MEDICAL BENEFITS
Preferred Provider Organization (PPO) – Health Savings Account (HSA) – 2500 PH01
Effective Date: January 1, 2026
Benefit Year: The-12-month period beginning each January 1 and ending each December 31.

PriorityGPS (Guided Personalized Support) is personalized member support and navigation available with your employer plan. PriorityGPS will provide guidance to help you understand, access, and use your health plan benefits, including prescription drug coverage. Your PriorityGPS member support team can help answer your claims and billing questions, schedule appointments, find the right provider, or enroll in available health programs focused on maintaining overall well-being, as well as on improving a specific health and wellness condition, including chronic condition solutions and behavioral health. This personalized service is an added benefit at no cost to employees that makes your benefits simpler and less complex to navigate. Sign up for an online member account by visiting https://member.priorityhealth.com/login. To get the best use of your benefits call PriorityGPS at **833 415-4399**.

Network Benefits are provided by a network provider (except as otherwise provided by the Plan Document and Summary Plan Description (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 PriorityGPS at **833 415-4399** or access the Find a Doctor tool on the Priority Health website at https://member.priorityhealth.com/login.

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, providers 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 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 PriorityGPS at **833 415-4399**. 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).

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 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.

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 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); 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 benefit 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.

If you have individual coverage, you must meet the individual out-of-pocket limit below. If you have more than one person in your family, you have family coverage and the family out-of-pocket limit below must be met. The family out-of-pocket limit 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); penalties paid for failure to prior certify 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 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	$2,500 per individual; $5,000 per family per benefit year.	$5,000 per individual; $10,000 per family per benefit year.
Benefit Percentage Rate	100% paid by the plan; 0% paid by the participant, unless otherwise noted.	80% paid by the plan; 20% paid by the participant, unless otherwise noted.
Coinsurance Maximums Please note the deductible does not apply to the coinsurance maximum.	$2,000 per individual; $4,000 per family per benefit year. All services apply to the maximum except as noted.	$4,000 per individual; $8,000 per family per benefit year. All services apply to the maximum except as noted.
Out-of-Pocket Limit (Includes deductible, coinsurance and copayment expenses.)	$4,500 per individual; $9,000 per family per benefit year.	$9,000 per individual; $18,000 per family per benefit year
BENEFITS	**NETWORK BENEFIT**	**NON-NETWORK 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 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	Covered at 100%. Deductible does not apply.	Not covered.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.	Covered at 100%. Deductible does not apply.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Preventive Health Care Services (continued)		
Breast Magnetic Resonance Imaging (MRI Scan) (routine and non-routine)	Covered at 100% after deductible.	Covered at 100% after deductible.
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 covered.
Medical Office/Home Services		
Primary Care Providers Office/Home Visits (Including medication management visits.) (Includes Family Practice, General Practice, Pediatrics, Internal Medicine and Obstetrics/Gynecology.) (Face-to-face visit.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Virtual Care Services (Telehealth includes telephonic and telemedicine.) (Including Mental Health, Substance Use Disorder, medication management visits.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Retail Health Clinic Visits (Located within the United States.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Specialty Care Providers Office/Home Visits (Face-to-face visit.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Office Surgery	Covered at 100% after deductible.	Covered at 80% after deductible.
Office Injections	Covered at 100% after deductible.	Covered at 80% after deductible.
Allergy Injections	Covered at 100% after deductible.	Covered at 80% after deductible.
Allergy Testing and Serum	Covered at 100% after deductible.	Covered at 80% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office or freestanding facility.)	Covered at 100% after deductible.	Covered at 80% after deductible. **Genetic Testing services are not covered when available by a participating provider.**
Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) (Performed in physician's office or freestanding facility.) Prior certification required.	Covered at 100% after deductible.	Covered at 80% after deductible.
Maternity Services (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 80% 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 100% after deductible.	Not covered.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
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 100% after deductible.	Covered at 80% after deductible.
Inpatient Professional and Surgical Charges	Covered at 100% after deductible.	Covered at 80% after deductible.
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 100% after deductible.	Covered at 80% after deductible.
Approved Clinical Trial Expenses (Routine expenses related to an approved clinical trial.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center facility charges.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 100% after deductible.	Covered at 80% after deductible.
Maternity Services in Hospital (Delivery, facility and anesthesia services.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Hospital Diagnostic Laboratory & Radiology Services	Covered at 100% after deductible.	Covered at 80% after deductible. **Genetic Testing services are not covered when available by a participating provider.**
Hospital Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) Prior certification required for outpatient services.	Covered at 100% after deductible.	Covered at 80% 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**	Covered at 100% after deductible. Prior certification required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and varicose veins treatments. Additional limitations may apply. 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 80% after deductible. Prior certification required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and varicose veins treatments. Additional limitations may apply. Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered at 100% after deductible.	Paid at the Network 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.		
Ambulance Services	Covered at 100% after deductible.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	Covered at 100% after deductible.	Covered at 80% after deductible.
Behavioral Health Services - Prior certification by the 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 100% after deductible.	Covered at 80% after deductible.
Outpatient Mental Health Services (Face-to-face visit.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Outpatient Substance Use Disorder Services (Face-to-face visit.)	Covered at 100% after deductible.	Covered at 80% 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.	Covered at 50% after deductible.
Vasectomy	Covered at 100% after deductible.	Covered at 80% after deductible.
Tubal Ligation/Tubal Obstructive Procedures (Included as part of the Women's Preventive Health Services benefits.)	Covered at 100%, deductible waived when performed at outpatient facilities. If received during an inpatient stay, only the services related to the tubal ligation/tubal obstructive procedure are covered in full, deductible waived.	Covered at 80% 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 80% after deductible.
Elective Abortions	Not covered.	Not covered.
Rehabilitative Medicine Services – Not related to Autism Treatment		
Physical and Occupational Therapy (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 60 visits per benefit year.	Covered at 80% after deductible up to a benefit maximum of 60 visits per benefit year.
Speech Therapy (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 60 visits per benefit year.	Covered at 80% after deductible up to a benefit maximum of 60 visits per benefit year.
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 30 visits per benefit year.	Covered at 80% after deductible up to a benefit maximum of 30 visits per benefit year.
Chiropractic and Osteopathic Manipulation Services (Includes maintenance care.) (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 24 visits per benefit year.	Covered at 80% after deductible up to a benefit maximum of 24 visits per benefit year.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Habilitation Services - Related to the Treatment of Autism Spectrum Disorder		
Physical, Occupational and Speech Therapy for the Treatment of Autism Spectrum Disorder	Covered at 100% after deductible.	Covered at 80% after deductible.
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder Prior certification is required.	Covered at 100% after deductible.	Covered at 80% after deductible.
Other Services		
Diabetes Services and Supplies	Covered at 100% after deductible.	Covered at 50% after deductible.
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 Dysfunction or Syndrome Treatment	Covered at 50% after deductible.	Covered at 50% after deductible.
Orthognathic Surgery	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 (Combined maximum for all services.) Prior certification required.	Covered at 100% after deductible up to 90 days per benefit year.	Covered at 80% after deductible up to 90 days per benefit year.
Hospice Services	Covered at 100% after deductible.	Covered at 80% after deductible.
Home Health Services and Infusion Therapy (Excluding rehabilitative medicine.) Prior certification required.	Covered at 100% after deductible.	Covered at 80% 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 aids covered in full to a maximum benefit of $1,500 for monaural and $2,542 for binaural hearing aids every 36 months. Deductible applies.	Not covered.
Custodial Care/Private Duty Nursing/Home Health Aides	Not covered.	

Pharmacy Benefits – Participating Pharmacies	
Prescription Drugs – Managed Formulary Includes disposable needles, syringes for diabetics and infertility medications. CGM available at pharmacy only, covered at 100%. Excludes select sexual dysfunction and weight loss 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 plan deductible and out-of-pocket maximum. Copayments apply after satisfaction of the deductible. Retail Pharmacy (up to 31 days): Tier 1 Drugs: $10 copayment Tier 2 Drugs: 20% copayment; minimum $40, maximum $80 Tier 3 Drugs: 20% copayment; minimum $80, maximum $160 Tier 4 Drugs: 20% copayment; minimum $40, maximum $80 Tier 5 Drugs: 20% copayment; minimum $80, maximum $160 Infertility Medications: 50% copayment Mail Service Program / Retail Pharmacy (90 days): Tier 1 Drugs: $20 copayment Tier 2 Drugs: 20% copayment; minimum $80, maximum $160 Tier 3 Drugs: 20% copayment; minimum $160, maximum $320 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 **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.
Full-Time Employee	30 hours worked per week.
Retiree Coverage	Not applicable.
Dependent Children	Covered to the end of the calendar month in which they turn age 26. Over age 26 if mentally or physically incapacitated dependent.
Motor Vehicle Injuries	Primary to motor vehicle insurance.
Motorcycle Injuries	Coordinated with 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 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.

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;
- Deductibles;
- Rehabilitative Medicine Services;
- Durable Medical Equipment (DME);
- Prosthetic and orthotic/support devices;
- Orthognathic surgery;
- Temporomandibular joint dysfunction or syndrome; and
- Family Planning/Infertility 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.

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.)