

**MECOSTA OSCEOLA ISD
SCHEDULE OF MEDICAL BENEFITS
Preferred Provider Organization (PPO) Plan
Effective Date: January 1, 2025**

Benefit Year: The 12-month period beginning each January 1 and ending each December 31.

Network Benefits are provided by a network provider (except as otherwise provided by the 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 the Customer Service Department at **616 956-1954** or **800 956-1954** or access the Find a Doctor tool on the Priority Health website at priorityhealth.com.

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

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

Network deductible, coinsurance and out-of-pocket amounts do not apply to non-network deductible, coinsurance and out-of-pocket amounts, and, non-network deductibles, coinsurance and out-of-pocket amounts do not apply to network deductible, coinsurance and out-of-pocket amounts.

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 BENEFITS	NON-NETWORK BENEFITS
Deductibles	\$500 per individual; \$1,000 per family per benefit year	\$1,000 per individual; \$2,000 per family per benefit year
Benefit Percentage Rate	80% paid by the plan; 20% paid by the participant, unless otherwise noted.	60% paid by the plan; 40% paid by the participant, unless otherwise noted.
Coinsurance Maximums Please note the deductible does not apply to the coinsurance maximum.	\$3,000 per individual; \$6,000 per family per benefit year. All services apply to the maximum except as noted.	Not applicable.
Out-of-Pocket Limit (Includes deductible, coinsurance and copayment expenses.)	\$4,500 per individual; \$9,000 per family per benefit year	\$4,500 per individual; \$9,000 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.	Covered at 60% after deductible.
Women's Preventive Health Care Services	Covered at 100%. Deductible does not apply.	Covered at 60% after deductible.
Routine Laboratory Tests, Screening and Counseling	Covered at 100%. Deductible does not apply.	Covered at 60% after deductible.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.	Covered at 60% after deductible.
Routine Breast Magnetic Resonance Imaging (MRI Scan) (Routine and non-routine.)	Covered at 100%. Deductible does not apply.	Covered at 60% after deductible.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%. Deductible does not apply.	Covered at 60% after deductible.
Immunizations	Covered at 100%. Deductible does not apply.	Covered at 60% after deductible.
Certain Drugs and Medications	Covered at 100%. Deductible does not apply.	Covered at 60% 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 Providers Office/Home Visits (Includes Family Practice, General Practice, Pediatrics, Internal Medicine and Obstetrics/Gynecology.) Face-to-face visits.	\$30 copayment per visit. Deductible does not apply.	Covered at 60% after deductible.
Virtual Care Services (Telehealth includes telephonic and telemedicine.) (Including medication management visits.)	\$30 copayment per visit. Deductible does not apply.	Covered at 60% after deductible.
Retail Health Clinic Visits (Located within the United States)	\$60 copayment per visit for evaluation and management services. Deductible does not apply.	Covered at 60% after deductible.
Specialty Care Providers Office/Home Visits Face-to-face.	\$50 copayment per visit. Deductible does not apply.	Covered at 60% after deductible.
Office Surgery	Covered at 80% after deductible.	Covered at 60% after deductible.
Office Injections	Covered at 80% after deductible.	Covered at 60% after deductible.
Allergy Services (Including allergy testing and injections, including serum costs.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office or freestanding facility.)	Covered at 80% after deductible.	Covered at 60% after deductible. Genetic Testing services are not covered when available in the Priority Health Service Area.
Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies) (Performed in physician's office or freestanding facility.) Prior certification required.	Covered at 80% after deductible.	Covered at 60% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Office/Home Services (Continued).		
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 60% after deductible.
Prenatal Classes	Attendance at an approved maternity education program is covered at 100%. Deductible does not apply.	Covered at 60% after deductible.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	\$50 copayment per visit. 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 80% after deductible.	Covered at 60% after deductible.
Inpatient Professional and Surgical Charges	Covered at 80% after deductible.	Covered at 60% after deductible.
Obstetrical Services in Hospital (Delivery, facility and anesthesia services.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 80% after deductible.	Covered at 60% after deductible.
Approved Clinical Trial Expenses (Routine expenses related to an approved clinical trial.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center facility charges.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 80% after deductible.	Covered at 60% after deductible.
Hospital Diagnostic Laboratory & Radiology Services	Covered at 80% after deductible.	Covered at 60% after deductible. Genetic Testing services are not covered when available in the Priority Health Service Area.
Hospital Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) Prior certification required.	Covered at 80% after deductible.	Covered at 60% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Hospital Services (Continued).		
Certain Surgeries and Treatments <ul style="list-style-type: none"> • 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 	<p>Covered at 80% after deductible.</p> <p>In addition, age limitations may apply to certain surgeries and treatments.</p> <p>**Prior certification required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty.</p> <p>Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.</p>	<p>Covered at 60% after deductible.</p> <p>In addition, age limitations may apply to certain surgeries and treatments.</p> <p>**Prior certification required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty.</p> <p>Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.</p>
<p>If the services of a surgical assistant are required for a surgical procedure, the non-network covered expenses will be the lesser of: (1) the amount charged by the assistant; or (2) 20% of the amount allowable to the physician who performed the surgery.</p>		
Medical Emergency and Urgent Care Services		
Emergency Room Services	\$150 copayment per visit. Deductible does not apply.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
<p>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 <u>does not</u> apply.</p>		
Ambulance Services	Covered at 80% after deductible.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	\$60 copayment per visit. Deductible does not apply.	Covered at 60% after deductible.
<p>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.</p>		
Inpatient Mental Health & Substance Use Disorder Services (Including subacute residential treatment and partial hospitalization.) Prior certification required except in emergencies.	Covered at 80% after deductible.	Covered at 60% after deductible.
Outpatient Mental Health Services Face-to-face.	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. \$30 copayment per visit. Deductible does not apply.	Covered at 60% after deductible.
Outpatient Substance Use Disorder Services Face-to-face.	\$30 copayment per visit. Deductible does not apply.	Covered at 60% 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. Prescription drugs for infertility treatment paid as shown under the prescription drug benefits shown below.	Not covered.
Vasectomy	Covered at 100%, deductible waived.	Not covered.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
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 in full. Deductible does not apply.	Covered at 60% 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 60% after deductible.
Rehabilitative Medicine Services – Not related to Autism Treatment		
Physical and Occupational Therapy (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a maximum of 30 visits per benefit year.	Covered at 60% after deductible up to a maximum of 30 visits per benefit year.
Speech Therapy (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a maximum of 30 visits per benefit year.	Covered at 60% after deductible up to a maximum of 30 visits per benefit year.
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a maximum of 30 visits per benefit year.	Covered at 60% after deductible up to a maximum of 30 visits per benefit year.
Chiropractic and Osteopathic Manipulation Services (Includes maintenance care.)(Combined Network/Non-Network Benefit.)	\$30 copayment up to a benefit maximum of 12 visits per benefit year. Deductible does not apply.	Covered at 60% after deductible up to a maximum of 12 visits per benefit year.
Habilitation Services Related to the Treatment of Autism Spectrum Disorder		
Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder	\$30 copayment per visit. Deductible does not apply.	Covered at 60% after deductible.
Speech Therapy for the Treatment of Autism Spectrum Disorder	\$30 copayment per visit. Deductible does not apply.	Covered at 60% after deductible.
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder Prior certification required.	Covered at 80% after deductible.	Covered at 60% after deductible.
Other Services		
Durable Medical Equipment Prior certification is required for charges over \$1,000.	Covered at 80% after deductible.	Covered at 60% after deductible.
Diabetic Services and Supplies	Covered at 100%. Deductible does not apply.	Covered at 60% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over \$1,000.	Covered at 80% after deductible.	Covered at 60% after deductible.
Temporomandibular Joint Dysfunction or Syndrome Treatment	Covered at 50% after deductible	Covered at 50% after deductible.
Orthognathic Surgery & Treatment	Covered at 50% after deductible	Covered at 50% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (Continued).		
Non-Hospital Facility Services – Including skilled nursing care services received in a: <ul style="list-style-type: none"> • Skilled Nursing Care Facility • Subacute Facility • Inpatient Rehabilitation Facilities Treatment • Hospice Facilities Prior certification required, except Hospice Facilities. (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to 90 days per benefit year.	Covered at 60% after deductible up to 45 days per benefit year.
Home Health Services and Infusion Therapy (Including hospice services, excluding rehabilitative medicine.) Prior certification required, except hospice services.	Covered at 80% after deductible.	Covered at 60% after deductible.
Radiation Therapy and Chemotherapy	Covered at 80% after deductible.	Covered at 60% after deductible.
Hemodialysis	Covered at 80% after deductible.	Covered at 60% after deductible.
Custodial Care/Private Duty Nursing/Home Health Aides	Not covered.	
Ear Care Services Covered for treatment of medical conditions and diseases of the ear only.	Covered at 80% after deductible.	Covered at 60% 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 80% after deductible.	Covered at 60% after deductible.
Hearing Care Services	One hearing exam, one audiometric exam and one basic hearing aid per ear every 36 months. Hearing and audiometric exams covered full. Hearing aid covered in full to a maximum benefit of \$1,500 for monaural and \$2,542 for binaural hearing aids every 36 months. Deductible waived.	Not covered.
Pharmacy Benefits – Participating Pharmacies		
Prescription Drugs – Managed Formulary Includes disposable needles and syringes for diabetics. CGM available at pharmacy only, covered at 100%. Includes Infertility medications. 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.	Deductible does not apply. <u>Retail Pharmacy (up to 31 days):</u> Tier 1 Drugs: \$20 copayment Tier 2 Drugs: \$40 copayment Tier 3 Drugs: \$80 copayment Tier 4 Drugs: \$40 copayment Tier 5 Drugs: \$80 copayment <u>Infertility Treatment:</u> 50% copay for drugs used for treating infertility. (Limitations apply.) <u>Mail Service Program (90 days):</u> Tier 1 Drugs: \$40 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 .
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 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. Deductible and out-of-pocket amounts are applied in the order that claims are processed for payment.

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, such as copayments for office visits, RX, ambulance and emergency services;
- 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 non-network 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 plan 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 non-network 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 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.)