THREE RIVERS COMMUNITY SCHOOLS
SCHEDULE OF MEDICAL BENEFITS
Preferred Provider Organization (PPO) – 3000 PHTR4
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	$3,000 per individual; $6,000 per family per benefit year.	$6,000 per individual; $12,000 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.
Out-of-Pocket Limit (Includes deductible, coinsurance and copayment expenses.)	$6,600 per individual; $13,200 per family per benefit year.	$8,600 per individual; $17,200 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.

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Preventive Health Care Services (continued)		
Routine Laboratory Tests, Screening and Counseling (Includes additional select lab procedures, ekg and chest x-ray.)	Covered at 100%. Deductible does not apply.	Not covered.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.	Not covered.
Routine Breast Magnetic Resonance Imaging (MRI Scan) (Routine and non-routine)	Covered at 100%. Deductible does not apply.	Not covered.
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 available.
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.)	$25 copayment per visit. Deductible does not apply.	Covered at 80% after deductible
Virtual Care Services (Telehealth includes telephonic and telemedicine.) (Including medication management visits.)	$0 copayment per visit. Deductible does not apply.	Covered at 80% after deductible
Retail Health Clinic Visits (Located within the United States)	$50 copayment per visit for evaluation and management services. Deductible does not apply.	$50 copayment per visit for evaluation and management services. Deductible does not apply.
Specialty Care Providers Office/Home Visits (Face-to-face visits.)	$25 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
Office Surgery	Included in the office visit benefit listed above.	Covered at 80% after deductible.
Office Injections	Included in the office visit benefit listed above.	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%. Deductible does not apply.	Covered at 80% 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.	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Maternity Services	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%. Deductible does not apply.	Not covered.

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Medical Office/Home Services (continued)		
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	$25 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 100% after deductible.	Covered at 80% after deductible.
Inpatient Professional and Surgical Charges *Evaluation and Management for Inpatient and Observation services covered at the Network rate when at a network facility.	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.
Hospital Diagnostic Laboratory & Radiology Services	Covered at 100%. Deductible does not apply.	Covered at 80% 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.	Covered at 100%. Deductible does not apply.	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** • **Sleep Apnea Treatment Procedures**	Covered at 100% 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 80% 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.
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.		

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Emergency and Urgent Care Services		
Emergency Room Services	$200 copayment per visit. Deductible applies.	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 and the emergency room services copayment does not apply.		
Ambulance Services	Covered at 100%. Deductible does not apply.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	$50 copayment per visit. Deductible does not apply.	$50 copayment per visit. Deductible does not apply.
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 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 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. $25 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
Outpatient Substance Use Disorder Services (Face-to-face visits.)	$25 copayment per visit. Deductible does not apply.	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.	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 does not apply.	Not covered.
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.	Not covered.
Elective Abortions	Not covered.	Not covered.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
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 60 visits per benefit year.	Covered at 80% after deductible up to a benefit maximum of 60 visits per benefit year.
Chiropractic and Osteopathic Manipulation Services (Includes maintenance care.) (Combined Network/Non-Network Benefit.)	$25 copayment up to a maximum of 30 visits per benefit year. Deductible does not apply.	Covered at 80% after deductible up to a benefit maximum of 30 visits per benefit year.
Habilitation Rehabilitative Medicine Services - Related to the Treatment of Autism Spectrum Disorder		
Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder	$25 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
Speech Therapy for the Treatment of Autism Spectrum Disorder	$25 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder Prior certification required.	Covered at 100% after deductible.	Covered at 80% after deductible.
Other Services		
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 80% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 80% 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.
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 Network/Non-Network Benefit.)	Covered at 100% after deductible up to 120 days per benefit year.	Covered at 80% after deductible up to 120 days per benefit year.
Home Health Services and Infusion Therapy (Including hospice services, excluding rehabilitative medicine.) Prior certification required, except hospice services.	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 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.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (continued)		
Private Duty Nursing (Combined Network/Non-Network Benefit.)	Covered at 80% after deductible up to a maximum of 90 days per benefit year.	Covered at 60% after deductible up to a maximum of 90 days per benefit year.
Pharmacy Benefits – Participating Pharmacies		
Prescription Drugs – Managed Formulary Includes disposable needles and syringes for diabetics, infertility medications. CGM available at pharmacy only, covered at 100%. Exclude 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: $10 copayment Tier 2 Drugs: $35 copayment Tier 3 Drugs: $60 copayment Tier 4&5 Drugs: 10% copayment up to a maximum of $150 per fill Infertility Drugs: 50% copayment Mail Service Program (90 days): Tier 1 Drugs: $25 copayment Tier 2 Drugs: $87.50 copayment Tier 3 Drugs: $150 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		
Waiting Period Requirement	Date of hire.	
Hourly Employee Requirements	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. Deductible and out-of-pocket amounts are applied in the order that claims are processed for payment.

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.)