BERRIEN REGIONAL EDUCATION SERVICE AGENCY
SCHEDULE OF MEDICAL BENEFITS
Preferred Provider Organization (PPO) - Plan A
Effective Date: July 1, 2024
Plan Year: The 12 month period beginning each July 1 and ending each June 30.

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 prioritythealth.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. Your provider 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, you 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 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 amounts apply to non-network deductible amounts, and, non-network deductible amounts apply to network deductible amounts.

Carry-over: Deductible amounts met in the last three months of the year will be applied towards the deductible amount for the next plan 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 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 plan year.	$1,000 per individual; $2,000 per family per plan 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	Not applicable.	$3,000 per individual; $6,000 per family per plan year.
Medical Out-of-Pocket Limit (Includes deductible and medical copayment expenses.)	$3,000 per individual; $6,000 per family per plan year.	Not applicable.
Prescription Drug Out-of-Pocket Limit (Includes prescription drug copayment expenses.)	$3,600 per individual; $7,200 per family per plan year.	Not applicable.

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 80% after deductible.
Women's Preventive Health Care Services(Includes routine pre-and postnatal services for employees or 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 80% after deductible.
Routine Laboratory Tests, Screening and Counseling (Includes additional select lab procedures, ekg and chest x-ray.)	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Immunizations (At a pharmacy or Health Dept.)	Covered at 100%. Deductible does not apply.	Covered at 100%. Deductible does not apply.
Immunizations (All other locations)	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Certain Drugs and Medications	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Virtual Care Services		
Virtual Care Services Limited-service virtual care only.	$30 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
Medical Office/Home Services		
Primary Care Providers Office/Home Visits Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management visits.) (Includes Family Practice, General Practice, Pediatrics, Internal Medicine, and Obstetrics/Gynecology.)	$30 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
Specialty Care Providers Office/Home Visits Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management visits.)	$30 copayment per visit. Deductible does not apply.	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 Services (Including allergy testing and injections, including serum costs.)	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.
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.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Office Services (continued)		
Maternity Services **(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 80% after deductible.
Maternity Education Classes	Not covered.	Not covered.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	$30 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
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.
Maternity Professional Services and Facility Expenses (Delivery, facility and anesthesia services.)	Covered at 100% after deductible. **Dependent maternity services /delivery expenses are not covered.**	Covered at 80% after deductible. **Dependent maternity services /delivery expenses are not covered.**
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% after deductible.	Covered at 80% after deductible.
Hospital Advanced Diagnostic Imaging Services (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) Prior certification required for outpatient services.	Covered at 100% after deductible.	Covered at 80% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Hospital Services (Continued)		
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. In addition, age limitations may apply to certain surgeries and treatments.	Covered at 80% after deductible. *Prior certification required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. In addition, age limitations may apply to certain surgeries and treatments.
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.		
Medical Emergency and Urgent Care Services		
Emergency Room Services	$150 copayment per visit after deductible then covered at 100%.	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% after deductible.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	$30 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
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 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 and telehealth (includes telephonic and telemedicine). (Including medication management visits.)	$30 copayment per visit. Deductible does not apply.	Covered at 80% after deductible.
Outpatient Substance Use Disorder Services Face-to-face and telehealth (includes telephonic and telemedicine). (Including medication management visits.)	$30 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.	Office visits are covered with a $30 copay per visit, deductible does not apply. All other services are covered at 100% after deductible.	Covered at 80% after deductible.
Fertility Treatment Services related to induction of pregnancy with infertility diagnosis codes. (Combined Network/Non-Network Benefit.)	Office visits are covered with a $30 copay per visit, deductible does not apply. All other services are covered at 100% after deductible. $500 lifetime maximum. Drugs do not track toward above limit, but are reimbursable under medical through direct reimbursement.	Covered at 80% after deductible. $500 lifetime maximum. Drugs do not track toward above limit, but are reimbursable under medical through direct reimbursement.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Family Planning and Reproductive Services (Continued)		
Vasectomy Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.	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 does not apply.	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 does not apply.	Covered at 80% after deductible.
Elective Abortions	Not covered.	Not covered.
Rehabilitative Medicine Services – Not related to Autism Treatment		
Physical and Occupational Therapy	Covered at 100% after deductible.	Covered at 80% after deductible.
Speech Therapy	Covered at 100% after deductible.	Covered at 80% after deductible.
Cardiac Rehabilitation and Pulmonary Rehabilitation	Covered at 100% after deductible.	Covered at 80% after deductible.
Chiropractic Services (Includes maintenance care and chiropractic massage performed by a chiropractor.) (Combined Network/Non-Network Benefit.)	Office visits are covered with a $30 copay per visit, deductible does not apply. All other services are covered at 100% after deductible. Chiropractic manipulations and massage therapy covered up to a combined maximum of 25 visits per plan year.	Office visits are covered with a $30 copay per visit, deductible does not apply. All other services are covered at 80% after deductible. Chiropractic manipulations and massage therapy covered up to a combined maximum of 25 visits per plan year.
Services Related to the Treatment of Autism Spectrum Disorder		
Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder	Covered at 100% after deductible	Covered at 80% after deductible.
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	Not covered.	Not covered.
Other Services		
Illness and Accidental Related Dental Services Limited to treatment within six months of the accident.	Office visits are covered with a $30 copay per visit, deductible does not apply. All other services are covered at 100% after deductible.	Covered at 80% after deductible.
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.
Wigs Related to a medical condition. (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible. $500 lifetime maximum.	Covered at 80% after deductible. $500 lifetime maximum.
Temporomandibular Joint Syndrome (TMJS) Treatment (Combined Network/Non-Network Benefit.) Includes bite splints.	Office visits are covered with a $30 copay per visit, deductible does not apply. All other services are covered at 100% after deductible. $1,000 lifetime maximum for non-surgical treatment.	Covered at 80% after deductible. $1,000 lifetime maximum for non-surgical treatment.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (Continued)		
Orthognathic Surgery & Treatment	Office visits are covered with a $30 copay per visit, deductible does not apply. All other services are covered at 100% after deductible.	Covered at 80% 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.	Covered at 100% after deductible	Covered at 80% after deductible.
Home Health Services and Infusion Therapy (Includes home health aides.) Prior certification required. (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to 40 visits per plan year per person.	Covered at 80% after deductible up to 40 visits per plan year per person.
Radiation Therapy and Chemotherapy	Covered at 100% after deductible	Covered at 80% after deductible.
Hemodialysis	Covered at 100% after deductible	Covered at 80% after deductible.
Private Duty Nursing	Covered at 100% after deductible	Covered at 80% after deductible.
Hearing Care (Combined Network/Non-Network Benefit.)	Exams and Evaluations: $30 copayment per visit. Deductible does not apply. Conformity Tests and Hearing Aids: Covered at 100% after deductible. $300 maximum benefit paid for Audiometric Examinations, Hearing Aid Evaluations, and Conformity Tests per person in any 36-Consecutive-month period. $500 maximum benefit paid for a Hearing Aid per covered person, per ear, in any 36-consecutive-month period.	Covered at 80% after deductible. $300 maximum benefit paid for Audiometric Examinations, Hearing Aid Evaluations, and Conformity Tests per person in any 36-Consecutive-month period. $500 maximum benefit paid for a Hearing Aid per covered person, per ear, in any 36-consecutive-month period.
Pharmacy Benefits – Participating Pharmacies		
Prescription Drugs – Managed Formulary Step-therapy does not apply. Includes disposable needles and syringes for diabetics, and sexual dysfunction medications. Excludes weight loss and infertility medications. (See medical infertility benefits above.) 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. Member pay difference only applies if no DAW.	Deductible does not apply. Retail Pharmacy (up to 34 days): Tier 1 Drugs: $20 copayment Tiers 2&4 Drugs: $50 copayment Tiers 3&5 Drugs: $100 copayment Mail Service Program (90 days): Tier 1 Drugs: $20 copayment Tier 2 Drugs: $50 copayment Tier 3 Drugs: $100 copayment For information about the mail order program, visit their website at express-scripts.com. Prescription Drug Maximum Out-of-Pocket per Plan Year: $3,600 per individual* $7,200 per family* *Includes prescription drug co-payments only. Does not include amounts attributed to the Total Maximum Out-of-Pocket for medical services, any optional additional amount that the covered person must pay over and above the co-payment, or the cost of any drug or service that is not covered under the Plan.	

Pharmacy Benefits – Participating Pharmacies	
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.
Full-Time Employee	30 hours worked per week.
Part-Time Employee	20 hours worked per week.
Retiree Coverage	Not applicable.
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	Coordinated with motor vehicle insurance.
Motorcycle Injuries	If a covered person is injured in an accident that involves a motor vehicle, claims will be processed in accordance with the Plan's position on motor vehicle accidents. **IF A COVERED PERSON IS OPERATING A MOTORCYCLE AND IS INJURED IN AN ACCIDENT THAT DOES NOT INVOLVE A MOTOR VEHICLE, THIS PLAN WILL EXCLUDE COVERAGE FOR THE FIRST $20,000 IN ELIGIBLE CHARGES OR, IF GREATER, THE AMOUNT OF HEALTH BENEFITS PAYABLE BY 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 plan year, except as described below. If the individual coinsurance maximum is reached during a plan year, the benefit percentage is 100% of covered expenses incurred by that person for the rest of the plan year**.** If the family coinsurance maximum is reached during a plan year, the benefit percentage is 100% of covered expenses for the employee and all the employee's covered dependents for the rest of the plan 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; and
- Deductibles;

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 plan year, the plan will pay 100% of covered expenses incurred by that person for the rest of the plan year. If the family out-of-pocket limit is reached during a plan year, the plan will pay 100% of covered expenses for the employee and all the employee's covered dependents for the rest of the plan 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 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 plan 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.)