OTSEGO PUBLIC SCHOOLS
SCHEDULE OF MEDICAL BENEFITS
Point of Service (POS)
High Deductible Health Plan (HDHP) - LEVEL PHOT1
Effective Date: September 1, 2024
Amended and Restated Effective: January 1, 2025
Benefit Year: The initial 16 month period shall be September 1st to December 31st thereafter the 12 month period beginning each January 1st and ending each December 31st.

Preferred Benefits are provided by your primary care provider (PCP) or by a participating provider for office services. Services may require prior certification with the Benefit Administrator when prior certification is considered necessary (except in a medical emergency). Referrals by your PCP to a non-participating provider must also be prior certified by Priority Health. For a directory of Priority Health and Cigna Open Access participating providers, call the Customer Service Department at **616 956-1954 or 800 956-1954** or access the Find a Doctor tool on the Priority Health website at prioritynhealth.com. Employees who reside outside of Michigan will be assigned the Cigna Primary Network.

Alternate Benefits are not coordinated through your PCP, and are provided by non-participating providers. Services may require the satisfaction of deductibles, coinsurance, and are subject to reasonable and customary charges. Some benefits must be prior certified with the Benefit Administrator when prior certification is considered necessary (except in a medical emergency).

Prior Certification: Prior certification is required for all inpatient hospital or facility services. Providers must access the Priority Health provider portal to prior certify services. You do not need prior certification from the Benefit Administrator for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Other services requiring prior certification are:

- Home Health Care
- Skilled Nursing, Sub acute & Long-term Acute Facility Care
- Inpatient Rehabilitation Care
- Durable Medical Equipment over $1,000
- Clinical Trials (all stages) for Cancer or a Life-threatening Illness/Condition
- Transplants
- Advanced Diagnostic Imaging Services
- Prosthetic Devices over $1,000
- Certain Surgeries and Treatments

The full list of services that require prior certification is included in the Plan Document and Summary Plan Description (PDSPD) and may be updated from time to time. A current listing is also available by calling the Priority Health Customer Service Department at **616 956-1954** or **800 956-1954**. Other services may be prior certified by you or your provider to determine medical/clinical necessity before treatment. Prior certification is not a guarantee of coverage or a final determination of benefits under this Plan.

If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, your provider must notify the Behavioral Health Department as soon as possible at **616 464-8500** or **800 673-8043**.

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:

- Preferred preventive health services that are listed in Priority Health's preventive health care guidelines when provided by a participating provider.
- Preferred routine maternity services provided in your physician's office (deductible **will** apply to delivery, facility charges and anesthesia charges associated with the delivery) when provided by a participating provider.
- Certain drugs set forth in IRS Notice 2004-50 and Notice 2019-45. Applicable copayments will not apply.
- Certain services and supplies set forth in IRS Notice 2019-45 to treat IRS allowed chronic conditions (such as A1c testing, Lipoprotein (LDL) testing, and glucometers) when provided by a participating provider. Applicable copayments or coinsurance will apply. Contact the Priority Health Customer Service Department at 616 956-1954 or 800 956-1954 or visit the Priority Health website at priorityhealth.com for a list of these drugs, services and supplies.

The Preferred Benefit Level and Alternate Benefit Level deductibles are calculated separately. You must meet the deductible at the Preferred Benefits Level before benefits will be paid for services you seek under the Preferred Benefits. If you choose to use the Alternate Benefits, you must meet the deductible at the Alternate Benefits Level before benefits will be paid for services you seek under the Alternate Benefits.

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 deductible amounts renew each benefit year. The preferred 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).

Out-of-Pocket Limits:

The out-of-pocket limits the total amount of covered expenses that you or your covered dependents will pay during a benefit year. Once the applicable out-of-pocket limit for the Preferred Benefits Level is met, all further medical covered services for that benefit year for Preferred Benefits will be paid at 100% of Priority Health's contracted rate. Once the applicable out-of-pocket limit for the Alternate Benefits Level is met, all further medical covered services for that benefit year for Alternate Benefits will be paid at 100% of the lesser of billed charges or reasonable and customary charges.

The amounts calculated toward the Preferred Benefits out-of-pocket limits do not apply to the amounts calculated toward the Alternate Benefits out-of-pocket limits, nor do the amounts calculated toward the Alternate Benefits out-of-pocket limits apply to the amounts calculated toward the Preferred Benefits out-of-pocket limits.

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 only the family out-of-pocket applies. The family out-of-pocket can be satisfied by only one family member or by any combination of family members.

Your out-of-pocket maximum renews each benefit year. The Preferred out-of-pocket maximum will include any monies paid for covered pharmacy services.

Notwithstanding the above, the following out-of-pocket costs do not apply toward the out-of-pocket limit: Services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); and, costs paid by participant for Alternate 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	PREFERRED BENEFITS	ALTERNATE BENEFITS
Deductibles	$2,200 per individual; $4,400 per family per benefit year.	$4,400 per individual; $8,800 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.
Out-of-Pocket Limit (Includes deductible, coinsurance and copayment expenses.)	$2,650 per individual; $5,300 per family per benefit year.	$5,300 per individual; $10,600 per family per benefit year.
BENEFITS	**PREFERRED BENEFIT**	**ALTERNATE BENEFIT**
Preventive Health Care Services - Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available in the member center at 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.

BENEFITS	PREFERRED BENEFIT	ALTERNATE BENEFIT
Preventive Health Care Services - Continued		
Routine Laboratory Tests, Screening and Counseling (includes routine pre- and postnatal services for employees or covered spouses and routine prenatal care services required by the PPACA for dependent children.)	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.
Breast Magnetic Resonance Imaging (MRI Scan) (Routine and Non-Routine)	Covered at 100%. after deductible.	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		
Your Primary Care Provider (PCP) - Office Visit (Your selected or assigned PCP and/or PCP Practice.) (Face-to-face visit.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Virtual Care Services (Telehealth includes telephonic and telemedicine.) (Including medication management visits.)	Covered at 100% after deductible.	Covered at 60% after deductible.
Retail Health Clinic Visits (Located within the United States.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Specialty Care Providers Office Visits (Face-to-face visit.)	Covered at 80% after deductible.	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 Injections	Covered at 80% after deductible.	Covered at 60% after deductible.
Allergy Testing and Serum	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 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 80% after deductible.	Covered at 60% after deductible.
Obstetrical Services by Physician (Including prenatal and postnatal care.) **(Dependent children's obstetrical 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 60% after deductible.
Maternity Education Classes	Attendance at an approved maternity education program is covered at 100% after deductible.	Not covered.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Medical Office/Home Services - Continued		
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	Covered at 80% after deductible.	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.
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.
Maternity Services in Hospital (Delivery, facility and anesthesia services.) **Dependent maternity services expenses are not covered.**	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 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 80% after deductible.	Covered at 60% after deductible.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
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 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 to correct or reverse complications from a previous bariatric procedure.	Covered at 60% 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 to correct or reverse complications from a previous bariatric procedure.
If the services of a surgical assistant are required for a surgical procedure, the Alternate covered expenses will be the lesser of: (1) the amount charged by the assistant; or (2) 20% of the amount allowable to the physician who performed the surgery.		
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered at 80% after deductible.	Paid at the Preferred Benefit Level. Reasonable and customary limitations apply.
Note: If you are admitted for hospital inpatient care or hospital observation care from the emergency room, your emergency room charges will be paid under the Hospital Services benefits.		
Ambulance Services	Covered at 80% after deductible.	Paid at the Preferred Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	Covered at 80% after deductible.	Covered at 60% 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 80% after deductible.	Covered at 60% after deductible.
Outpatient Mental Health Services (Face-to-face visit.)	The first three visits (within 90 days of discharge) from a network hospital for mental health inpatient care are covered at 100% after deductible. Visits thereafter apply as noted below. Covered at 80%, after deductible.	Covered at 60% after deductible.
Outpatient Substance Use Disorder Services (Face-to-face visit.)	Covered at 80% after deductible.	Covered at 60% 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.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Family Planning and Reproductive Services - Continued		
Vasectomy	Covered at 80% after deductible.	Covered at 60% 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 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 waived.	Covered at 60% after deductible.
Elective Abortions	Not covered.	Not covered.
Rehabilitative Medicine Services – Not related to Autism Treatment		
Physical and Occupational Therapy (Combined Preferred/Alternate Benefit.)	Covered at 80% after deductible up to a benefit maximum of 50 visits per benefit year.	Covered at 60% after deductible up to a benefit maximum of 50 visits per benefit year.
Speech Therapy (Combined Preferred/Alternate Benefit.)	Covered at 80% after deductible up to a benefit maximum of 50 visits per benefit year.	Covered at 60% after deductible up to a benefit maximum of 50 visits per benefit year.
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Preferred/Alternate Benefit.)	Covered at 80% after deductible up to a benefit maximum of 50 visits per benefit year.	Covered at 60% after deductible up to a benefit maximum of 50 visits per benefit year.
Chiropractic and Osteopathic Manipulation Services (Includes maintenance care.) (Combined Preferred/Alternate Benefit.)	Covered at 80% after deductible up to a benefit maximum of 30 visits per benefit year.	Covered at 60% after deductible up to a benefit maximum of 30 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	Covered at 80% after deductible.	Covered at 60% after deductible.
Speech Therapy for the Treatment of Autism Spectrum Disorder	Covered at 80% after deductible.	Covered at 60% after deductible.
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder Prior certification is 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 100% after deductible.	Covered at 50% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 50% after deductible.
Diabetic Services and Supplies	Covered at 100% 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	Covered at 50% after deductible.	Covered at 50% after deductible.

BENEFITS	PREFERRED BENEFITS	ALTERNATE BENEFITS
Other Services - Continued		
Non-Hospital Facility Services – Including skilled nursing care services received in a: • Skilled Nursing Care Facility • Subacute Facility • Inpatient Rehabilitation Facilities Treatment (Combined Preferred/Alternate Benefit.) Prior certification required.	Covered at 80% after deductible up to 45 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.	Covered at 80% after deductible.	Covered at 60% after deductible.
Hospice	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 in 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.
Custodial Care/Private Duty Nursing/Home Health Aides	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 and 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.	Covered prescription drugs apply to the plan deductible and out-of-pocket maximum. Copayments apply after satisfaction of the deductible. <u>Retail Pharmacy (up to 31 days):</u> Tier 1 Drugs: $10 copayment Tier 2 Drugs: $40 copayment Tier 3 Drugs: $80 copayment Tier 4 Drugs: $40 copayment Tier 5 Drugs: $80 copayment <u>Infertility Drugs</u>: 50% <u>Mail Service Program (90 days):</u> Tier 1 Drugs: $20 copayment Tier 2 Drugs: $80 copayment Tier 3 Drugs: $160 copayment For information about the mail order program, visit their website at <u>express-scripts.com</u>. Certain drugs set forth in IRS Notice 2004-50 and Notice 2019-45 shall be covered prior to satisfying your deductible. Applicable copayments listed above will apply.	
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.
Full-Time Employee	30 hours or more worked per week.
Part-Time Employee	20 – 29 hours worked per week.
Retiree Coverage	Not applicable.
Dependent Children	Covered 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 coordinates with the motor vehicle insurance policy.
Motorcycle Injuries	This plan coordinates with 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 if medically/clinically necessary, and
- Prior certification for the extension is obtained before exceeding the number of prior certified days.

For emergency admissions, the Benefit Administrator should be notified as soon as reasonably possible.

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