

**TRENTON PUBLIC SCHOOLS  
SCHEDULE OF MEDICAL BENEFITS  
Preferred Provider Organization (PPO) Plan – 250 PHTN2  
Effective Date: January 1, 2026**

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

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

**Network Benefits** are provided by a network provider (except as otherwise provided by the Plan Document and Summary Plan Description (PDSPD)), and may require prior certification with the Benefit Administrator (except in a medical emergency). For a directory of Priority Health and Cigna Open Access network providers, call PriorityGPS at **833 415-4399** or access the Find a Doctor tool on the Priority Health website at <https://member.priorityhealth.com/login>. Employees who reside outside of Michigan will be assigned the Cigna Primary Network.

**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 PriorityGPS at **833 415-4399**. Other services may be prior certified by you or your provider to determine medical/clinical necessity before treatment. Prior certification is not a guarantee of coverage or a final determination of benefits under this plan.

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.

**Carry-over:** Network deductible amounts met in the last three months of the benefit year will be applied towards the network deductible amount for the next benefit year. Deductible amounts carried over to the next benefit year will not apply to your Out-of-Pocket Limits.

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
<b>Deductibles</b>	\$250 per individual; \$500 per family per benefit year.	\$500 per individual; \$1,000 per family per benefit year.
<b>Benefit Percentage Rate</b>	90% paid by the plan; 10% paid by the participant, unless otherwise noted.	70% paid by the plan; 30% paid by the participant, unless otherwise noted.

<b>BENEFITS</b>	<b>NETWORK BENEFIT</b>	<b>NON-NETWORK BENEFIT</b>
<b>Coinsurance Maximums</b> All services apply to the maximum except as noted.	\$1,500 per individual; \$3,000 per family per benefit year.	\$3,000 per individual; \$6,000 per family per benefit year.
<b>Out-of-Pocket Limit</b> (Includes deductible, coinsurance and copayment expenses.)	\$9,200 per individual; \$18,400 per family per benefit year.	\$18,400 per individual; \$36,800 per family per benefit year.
<b>BENEFITS</b>	<b>NETWORK BENEFIT</b>	<b>NON-NETWORK BENEFIT</b>
<b>Preventive Health Care Services</b> - Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available in the member center at <a href="http://priorityhealth.com">priorityhealth.com</a> 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.		
<b>Routine Adult Physical Exams, Screening and Counseling</b>	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Women's Preventive Health Care Services</b>	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Routine Laboratory Tests, Screening and Counseling</b>	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Routine Prostate-Specific Antigen (PSA) tests</b>	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Well Child and Adolescent Care, Screening and Assessments</b>	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Immunizations</b>	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Certain Drugs and Medications</b>	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Diabetic Care Services Program Provided by Virta Health only.</b>	Covered at 100%. Deductible does not apply.	Not covered.
<b>Medical Office/Home Services</b>		
<b>Primary Care Providers Office/Home Visits</b> (Includes Family Practice, General Practice, Pediatrics, Internal Medicine and Obstetrics/Gynecology.) (Face-to-face visits.)	\$20 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
<b>Virtual Care Services</b> (Telehealth includes telephonic and telemedicine.) (Including Mental Health, Substance Use Disorder, medication management visits.)	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Retail Health Clinic Visits</b> (Located within the United States.)	\$75 copayment per visit for evaluation and management services. Deductible does not apply.	Paid at the Network Benefit Level.
<b>Specialty Care Providers Office/Home Visits</b> (Face-to-face visits.)	\$35 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
<b>Office Surgery</b>	Included in the office visit benefit listed above.	Covered at 70% after deductible.
<b>Office Injections</b>	Included in the office visit benefit listed above.	Covered at 70% after deductible.
<b>Allergy Injections</b>	Covered at 90%. Deductible does not apply.	Covered at 70% after deductible.
<b>Allergy Testing and Serum</b>	Covered at 90%. Deductible does not apply.	Covered at 70% after deductible.
<b>Diagnostic Radiology and Lab Services</b> (Performed in physician's office or freestanding facility.)	Included in the office visit benefit listed above.	Covered at 70% after deductible.
<b>Advanced Diagnostic Imaging Services</b> (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies) (Performed in physician's office or freestanding facility.) Prior certification required.	\$150 copayment per test. Deductible applies.	Covered at 70% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
<b>Medical Office/Home Services (Continued.)</b>		
<b>Maternity Services</b>	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 70% after deductible.
<b>Maternity Education Classes</b>	Attendance at an approved maternity education program is covered at 100%. Deductible does not apply.	Not covered.
<b>Education Services</b> (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	\$35 copayment per visit. Deductible does not apply.	Not covered.
<b>Hospital Services</b>		
<b>Inpatient Hospital and Inpatient Longterm Acute Care Services</b> 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 90% after deductible.	Covered at 70% after deductible.
<b>Inpatient Professional and Surgical Charges</b> *Evaluation and Management for Inpatient and Observation services covered at the Network rate when at a network facility.	Covered at 90% after deductible.	Covered at 70% after deductible.
<b>Human Organ Tissue Transplants</b> Covered only with prior certification from Benefit Administrator.	Covered at 90% after deductible.	Covered at 70% after deductible.
<b>Approved Clinical Trial Expenses</b> (Routine expenses related to an approved clinical trial.)	Covered at 90% after deductible.	Covered at 70% after deductible.
<b>Outpatient Hospital Care and Observation Care Services</b> (Including ambulatory surgery center facility charges.)	Covered at 90% after deductible.	Covered at 70% after deductible.
<b>Outpatient Hospital Professional and Surgical Charges</b>	Covered at 90% after deductible.	Covered at 70% after deductible.
<b>Hospital Diagnostic Laboratory &amp; Radiology Services</b>	Covered at 90% after deductible.	Covered at 70% after deductible.
<b>Hospital Advanced Diagnostic Imaging Services</b> (Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.) Prior certification required for outpatient services.	\$150 copayment per test. Deductible applies.	Covered at 70% after deductible.
<b>Certain Surgeries and Treatments</b> <ul style="list-style-type: none"> <li>• <b>Bariatric Surgery</b></li> <li>• <b>Reconstructive Surgery:</b> blepharoplasty of upper eyelids, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and surgical treatment of male gynecomastia</li> <li>• <b>Skin Disorder Treatments:</b> 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.</li> <li>• <b>Varicose Veins Treatments</b></li> </ul>	<p>Covered at 90% after deductible.</p> <p>Prior certification required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and varicose veins treatments.</p> <p>Additional limitations may apply.</p> <p>Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary.</p>	<p>Covered at 70% after deductible.</p> <p>Prior certification required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and varicose veins treatments.</p> <p>Additional limitations may apply.</p> <p>Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary.</p>

<b>BENEFITS</b>	<b>NETWORK BENEFIT</b>	<b>NON-NETWORK BENEFIT</b>
<b>Medical Emergency and Urgent Care Services</b>		
<b>Emergency Room Services</b>	\$150 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 <u>does not</u> apply.		
<b>Ambulance Services</b>	\$150 copayment. Deductible applies.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
<b>Urgent Care Facility Services</b>	\$75 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
<b>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.</b>		
<b>Inpatient Mental Health &amp; Substance Use Disorder Services</b> (Including subacute residential treatment and partial hospitalization.) Prior certification required except in emergencies.	Covered at 90% after deductible.	Covered at 70% after deductible.
<b>Outpatient Mental Health Services</b> (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.  \$20 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
<b>Outpatient Substance Use Disorder Services</b> (Face-to-face visits.)	\$20 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
<b>Family Planning and Reproductive Services</b>		
<b>Infertility Counseling &amp; Treatment</b> 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.
<b>Vasectomy</b>	Covered at 90% after deductible.	Covered at 70% after deductible.
<b>Tubal Ligation/Tubal Obstructive Procedures</b> (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 70% after deductible.
<b>Birth Control Services Medical Plan</b> (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 70% after deductible.
<b>Elective Abortions</b>	Not covered.	Not covered.

<b>BENEFITS</b>	<b>NETWORK BENEFIT</b>	<b>NON-NETWORK BENEFIT</b>
<b>Rehabilitative Medicine Services – Not related to Autism Treatment</b>		
<b>Physical and Occupational Therapy</b> (Combined Network/Non-Network Benefit.)	\$20 copayment up to a benefit maximum of 30 visits per benefit year. Deductible applies.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
<b>Speech Therapy</b> (Combined Network/Non-Network Benefit.)	\$20 copayment up to a benefit maximum of 30 visits per benefit year. Deductible applies.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
<b>Cardiac Rehabilitation and Pulmonary Rehabilitation</b> (Combined Network/Non-Network Benefit.)	\$20 copayment up to a benefit maximum of 30 visits per benefit year. Deductible applies.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
<b>Chiropractic and Osteopathic Manipulation Services</b> (Includes maintenance care.) (Combined Network/Non-Network Benefit.)	\$20 copayment up to a benefit maximum of 30 visits per benefit year. Deductible applies.	Covered at 50% after deductible up to a benefit maximum of 30 visits per benefit year.
<b>Habilitation Services - Related to the Treatment of Autism Spectrum Disorder</b>		
<b>Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder</b>	\$20 copayment per visit. Deductible does not apply.	Covered at 50% after deductible.
<b>Speech Therapy for the Treatment of Autism Spectrum Disorder</b>	\$20 copayment per visit. Deductible does not apply.	Covered at 50% after deductible.
<b>Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder</b> Prior certification required.	\$20 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
<b>Other Services</b>		
<b>Durable Medical Equipment</b> Prior certification is required for charges over \$1,000.	Covered at 50% after deductible.	Covered at 50% after deductible.
<b>Diabetic Supplies &amp; Services</b>	Covered at 100%. Deductible does not apply.	Covered at 70% after deductible.
<b>Prosthetic &amp; Orthotic/Support Devices</b> Prior certification is required for charges over \$1,000.	Covered at 50% after deductible.	Covered at 50% after deductible.
<b>Temporomandibular Joint Dysfunction or Syndrome Treatment</b>	Covered at 50% after deductible.	Covered at 50% after deductible.
<b>Orthognathic Surgery &amp; Treatment</b>	Covered at 50% after deductible.	Covered at 50% after deductible.
<b>Non-Hospital Facility Services –</b> Including skilled nursing care services received in a: <ul style="list-style-type: none"> <li>• Skilled Nursing Care Facility</li> <li>• Subacute Facility</li> <li>• Inpatient Rehabilitation Facilities Treatment</li> <li>• Hospice Facilities</li> </ul> Prior certification required, except Hospice Facilities. (Combined Network/Non-Network Benefit.)	Covered at 90% after deductible up to 45 days per benefit year.	Covered at 70% after deductible up to 45 days per benefit year.
<b>Home Health Services and Infusion Therapy</b> (Excluding rehabilitative medicine.) Prior certification required, except hospice services.	Covered at 100% after deductible.	Covered at 70% after deductible.
<b>Hospice Care Services</b>	Covered at 100% after deductible.	Covered at 70% after deductible.
<b>Custodial Care/Private Duty Nursing/Home Health Aides</b>	Not covered.	Not covered.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
<b>Other Services (Continued.)</b>		
<b>Hearing Care Services</b>	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 does not apply.	Not covered.
<b>Pharmacy Benefits – Participating Pharmacies</b>		
<b>Prescription Drugs – Managed Formulary</b> Includes disposable needles and syringes for diabetics. CGM available at pharmacy only, covered at 100%. Includes 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.  <u>Retail Pharmacy (up to 31 days):</u> Tier 1 Drugs: \$10 copayment Tier 2&4 Drugs: \$40 copayment Tier 3&5 Drugs: \$80 copayment  <u>Infertility Drugs:</u> 50% copayment  <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 <a href="http://express-scripts.com">express-scripts.com</a> .	
<b>SaveOn Specialty Drug Program</b>	Filled through a participating 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 <b>1-800-683-1074</b> .	
<b>Coverage Information</b>		
<b>Waiting Period Requirement</b>	Date of hire.	
<b>Full-Time Employee</b>	30 hours worked per week.	
<b>Part-Time Employee</b>	Not applicable.	
<b>Retiree Coverage</b>	Not applicable.	
<b>Dependent Children</b>	Covered to the end of the month in which they turn age 26. Over age 26 if mentally or physically incapacitated dependent.	
<b>Motor Vehicle Injuries</b>	This plan is primary to the motor vehicle insurance policy.	
<b>Motorcycle Injuries</b>	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 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.)