MDA Health Plan

SCHEDULE OF MEDICAL BENEFITS

Preferred Provider Organization (PPO) Plan – Select PPO - OPTION 3

Effective Date: January 1, 2022

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

Network Benefits are provided by network providers (except as otherwise provided by this SPD), and may require prior certification with the Benefit Administrator (except in a medical emergency). For a current status of Priority Health network providers, call the Customer Service Department at **616-956-1954 or 800-956-1954**. 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. For employees residing outside the Priority Health service area additional networks are available: A listing of Sparrow Network providers is available on the Internet at sparrow.org/findadoc. A UPHP Regional Network provider listing is available by contacting UPHP at **800-835-2556** or checking the listing online at UPHP.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, unless otherwise noted. 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. Non-emergency admissions must be prior certified at least five working days before admission. For emergency admissions, you must notify the Benefit Administrator as soon as reasonably possible after admission. You or your physician must call **800-269-1260** 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 for assistance. Call the Behavioral Health department at **616-464-8500** or **800-673-8043** for assistance. You do not need prior approval 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 SPD 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 Summary Plan Description. 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 Summary Plan Description and any applicable amendments to the plan.

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Deductibles	$1,500 per individual $3,000 per employee +1 $4,500 per family	$3,000 per individual $6,000 per employee +1 $9,000 per family
Benefit Percentage Rate	80% paid by the plan; 20% paid by the participant, unless otherwise noted.	60% paid by the plan; 40% paid by the participant, unless otherwise noted.
Coinsurance Maximums (Does not include deductible or copayment expenses.)	$3,000 per individual $6,000 per employee +1 $9,000 per family	$6,000 per individual $12,000 per employee +1 $18,000 per family
Out-of-Pocket Limit (Includes deductible, coinsurance and copayment expenses.)	$8,550 per individual $13,650 per employee +1 $17,100 per family	$17,100 per individual $27,300 per employee +1 $34,200 per family
Reduction of Benefits Penalty	Not applicable.	$250 penalty applies if not prior certified.
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.		
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.
Mammograms (Medically necessary or preventive.)	Covered at 100% deductible does not apply.	Covered at 60% after deductible.
Routine Prostate-Specific Antigen (PSA)	Covered at 100%. Deductible does not apply.	Not covered.
Routine Laboratory Tests, Screening and Counseling	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.
Medical Office Services		
Office/Home Visits and Consultations (Includes visits not listed in Priority Health's Preventive Health Care Guidelines or routine maternity services.) Primary Care Providers include pediatricians, family practice, internists and select OB/gynecologists. Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits.)	$35 copayment per visit for Primary Care Provider (PCP) $70 copayment per visit for Specialty Care Provider (SCP) Deductible does not apply.	Covered at 60% after deductible
Virtual Care Services (E.g. Spectrum Health or MDLive acute virtual care providers.)	$35 copayment per visit. Deductible does not apply.	Not Applicable.
Retail Health Clinic Visits (Located within the United States)	$35 copayment per visit Deductible does not apply.	$35 copayment per visit at reasonable and customary charges. Deductible does not apply.
Office Surgery	Covered at 80% after deductible.	Covered at 60% after deductible.
Office Injections	Covered at 80% after deductible.	Covered at 60% after deductible.
Allergy Services (Including allergy testing, and injections, including serum costs.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office.)	Covered at 80% after deductible.	Covered at 60% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Office Services (Continued)		
Obstetrical Services by Physician (Including prenatal and postnatal care.)	Routine prenatal and postnatal visits are covered at 100%, deductible waived under the Preventive Health Care Services benefits above. See the Hospital Services section for facility and physician benefits related to delivery and nursery services.	Covered at 60% after deductible.
Maternity Education Classes	Attendance at an approved maternity education program is covered in full. Deductible does not apply.	Not covered.
Advanced Diagnostic Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies Prior certification required.	Covered at 80% after deductible.	Covered at 60% after deductible. $250 if not prior certified.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	$70 copayment. Deductible does not apply.	Not covered.
Hospital Services		
Inpatient Hospital and Inpatient Longterm Acute Care Services Prior approval 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. Prior certification phone number is **800-269-1260**.	Covered at 80% after deductible.	Covered at 60% after deductible. $250 penalty applies if not prior certified.
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.
Travel, Meals and Lodging Expenses Associated with Transplant Services Limited to $10,000 per transplant.	Covered at 80% after deductible.	Covered at 60% after deductible.
Approved Clinical Trial Expenses (Routine expenses related to an approved clinical trial.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center facility charges.)	Covered at 80% after deductible.	Covered at 60% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 80% after deductible.	Covered at 60% after deductible.
Hospital and Free Standing Facility Diagnostic Laboratory & Radiology Services	Covered at 80% after deductible.	Covered at 60% after deductible.
Hospital Advanced Diagnostic Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies Prior certification required.	Covered at 80% after deductible.	Covered at 60% after deductible. $250 penalty applies if not prior certified.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Hospital Services (continued)		
Certain Surgeries and Treatments • **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 approval required for panniculectomy, rhinoplasty and septorhinoplasty.	Covered at 60% after deductible. *Prior approval required for panniculectomy, rhinoplasty and septorhinoplasty.
Weight Loss Services • Physician-supervised weight loss programs. • Certain surgical treatments – limit one per lifetime. Prior approval required.	Covered at 80% after deductible. 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. 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 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	$100 copayment after deductible, then covered at 80%.	Paid at the Network Benefit Level. Reasonable and customary does not 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 80% after deductible.	Paid at the Network Benefit Level. Reasonable and customary does not apply.
Urgent Care Facility Services	$35 copayment per visit. Deductible does not apply.	Covered at 60% 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 Abuse 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. $250 penalty applies if not prior certified.
Outpatient Mental Health & Substance Abuse Services Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits.)	$35 copayment per visit. All other office services covered at 80% after deductible.	Covered at 60% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Family Planning and Reproductive Services		
Infertility Counseling & Treatment Covered for diagnosis and treatment of underlying cause only.	Covered at 80% after deductible. Office visit copayments may apply.	Covered at 60% after deductible.
Vasectomy Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.	Covered at 80% after deductible. Office visit copayments may apply.	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.
Rehabilitative Medicine Services – Not related to Autism Treatment		
Speech, Physical and Occupational Therapy (Combined maximum for all services.)	$70 copayment up to a benefit maximum of 60 visits per plan year. Deductible does not apply.	Covered at 60% after deductible up to a benefit maximum of 60 visits per plan year.
Cardiac Rehabilitation and Pulmonary Rehabilitation Limitations apply. (Combined maximum for all services.)	$70 copayment up to a benefit maximum of 30 visits per plan year. Deductible does not apply.	Covered at 60% after deductible up to a benefit maximum of 30 visits per plan year.
Services Related to the Treatment of Autism Spectrum Disorder (Available for children and adolescents through the age of 18 only)		
Physical, Occupational and Speech Therapy; Applied Behavioral Analysis (ABA) for Autism Treatment.	$70 copayment per visit. Deductible does not apply. Prior Approval required for ABA.	Covered at 60% after deductible. Prior Approval required for ABA.
Habilitative Medicine Services – Not related to Autism Treatment		
Speech, Physical and Occupational Therapy (Combined maximum for all services.)	$70 copayment up to a benefit maximum of 60 visits per plan year. Deductible does not apply.	Covered at 60% after deductible up to a benefit maximum of 60 visits per plan year.
Other Services		
Chiropractic Services (Includes maintenance care.)	$35 copayment for office visit and/or spinal manipulations. Limited to a maximum of 24 visits per plan year. X-rays covered at 80% after deductible.	Covered at 60% after deductible up to a maximum of 24 visits per plan year.
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 80% after deductible.	Covered at 60% after deductible. $250 penalty applies if not prior certified.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 80% after deductible.	Covered at 60% after deductible. $250 penalty applies if not prior certified.
Diabetes Services and Supplies	Covered at 100% deductible does not apply.	Covered at 60% after deductible.
Temporomandibular Joint Syndrome (TMJS) Treatment	Covered at 80% after deductible.	Covered at 60% after deductible. $250 penalty applies if not prior certified.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (Continued)		
Orthognathic Surgery & Treatment	Covered at 80% after deductible.	Covered at 60% after deductible. $250 penalty applies if not prior certified.
Accidental Dental Treatment must be completed within 6 months from date of accident. Dental implants are not covered.	Paid at the applicable benefit level of the service rendered.	Covered at 60% after deductible.
Skilled Nursing and Inpatient Rehabilitation Facilities Prior certification required. (Combined maximum for all services.)	Covered at 80% after deductible up to a maximum of 60 days per plan year.	Covered at 60% after deductible up to a maximum of 60 days per plan year. $250 penalty applies if not prior certified.
Home Health Services (including hospice services, excluding rehabilitative medicine) Prior certification required.	Covered at 80% after deductible.	Covered at 60% after deductible. $250 penalty applies if not prior certified.
Hospice	Covered at 100%. Deductible does not apply.	Not covered.
Hemodialysis, Radiation Therapy and Chemotherapy	Covered at 80% after deductible.	Covered at 60% after deductible.
Ear Care Services Covered for treatment of medical conditions and diseases of the ear only. Hearing aids are not covered.	Paid at the applicable benefit level of the service rendered.	Covered at 60% after deductible.
Eye Care Services Covered for treatment of medical conditions and diseases of the eye only. Refractive errors and vision supplies are not covered.	Paid at the applicable benefit level of the service rendered.	Covered at 60% after deductible.
Note: Vision and hearing benefits may be available – contact your Human Resources department for more information.		
Pharmacy Benefits – Participating Pharmacies		
Prescription Drugs – Managed Formulary Includes disposable needles and syringes for diabetics. Insulin pen needles to be dispensed as a tier 1 benefit. Sexual dysfunction medication limited to 12 pills per month. Any medications provided in the 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. Infertility medications are not covered.	<u>Retail Pharmacy (up to 31 day supply):</u> Tier 1a Drugs: $10 copayment Tier 1b Drugs: $20 copayment Tier 2 Drugs: $60 copayment Tier 3 Drugs: $120 copayment <u>Retail or Mail Service Program (up to 90 day supply):</u> Tier 1a Drugs: $20 copayment Tier 1b Drugs: $40 copayment Tier 2 Drugs: $120 copayment Tier 3 Drugs: $240 copayment <u>Specialty Pharmacy:</u> Tier 4 Drugs: 20% copayment up to a maximum of $200 per fill Tier 5 Drugs: 50% copayment up to a maximum of $500 per fill	
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**.	

Medical Plan Pharmacy Services	
Drugs Requiring Administration by a Health Professional (Injectable and infusible drugs requiring administration by a health professional in a medical office, home or outpatient facility.) Prior approval required.	Preferred Specialty Drug: 20% copayment up to a maximum per injection or infusion of $200. Non-Preferred Specialty Drug: 50% copayment up to a maximum per injection or infusion of $500. Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.

Approved Drug List.

A list of covered drugs that identifies tier placement and any utilization management (such as Prior Authorization, step therapy, and quantity limits) that are required. Tier placement determines what you pay for the drug, outlined in this *Schedule of Benefits*.

- **Tier 1a:** The least expensive prescription drugs available to you. This tier includes low-cost Generic Drugs—proven to be as safe as Brand Name Drugs—and, on some formularies, select Brand Name Drugs.
- **Tier 1b:** This tier includes low-cost Generic Drugs—proven to be as safe as Brand Name Drugs—and, on some formularies, select Brand Name Drugs.
- **Tier 2:** Includes preferred and lower cost brand name drugs, and some higher cost generic drugs. If you must take a brand name drug, you should work with your physician to choose one that is covered here, and the most affordable.
- **Tier 3:** Non-preferred and expensive brand name drugs, as well as higher-cost generic drugs. These drugs may cost you a significant amount out of pocket, so you should ask your physician if a tier 1 or 2 option can be prescribed instead.
- **Tier 4:** Includes very expensive brand name and generic drugs, and preferred specialty drugs used to treat complex conditions. Specialty drugs often have high costs and may have special handling or storage requirements. They are usually dispensed by trained personnel at specialty pharmacies. If you need to take a specialty drug, you should work with your physician to choose one that is covered here.
- **Tier 5:** Non-preferred specialty drugs, and the most expensive brand name and generic drugs are covered here because they offer limited clinical value. Most have a similar lower-cost option offering the same clinical value on tiers 1 through 4. Ask your physician about alternatives.

Coverage Information	
Waiting Period Requirement	As shown in the *Schedule of Eligibility* of the plan.
Full-Time Employee	As shown in the *Schedule of Eligibility* of the plan.
Retiree Coverage	Not applicable.
Dependent Children	Covered up to the end of the calendar year in which they turn age 26. Over age 26 if mentally or physically incapacitated dependent.
Motor Vehicle Injuries	This plan coordinates benefits with any available motor vehicle policy.
Motorcycle Injuries	This plan is secondary to motorcycle insurance.

In accordance with the terms and conditions of the SPD, you are entitled to covered services when these services are:

A. Medically/clinically necessary; and
B. Not excluded in the SPD.

If you seek services when prior certification is required and you do not receive prior certification, except in emergencies, you will be charged a penalty. You will also 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.

For emergency admissions, the Benefit Administrator should be notified by the end of the next business day following the admission or as soon as reasonably possible.

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. Flat dollar copays, including pharmacy copays, do not apply in meeting the deductible amount.

The “out-of-pocket limit” is the total amount of deductible, 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% for the employee and all of 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 to providers for non-network benefits that exceed reasonable and customary; and
- any monies you paid for non-covered services; and
- any monies for prior certification penalties; 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.)