**MONROE COUNTY COMMUNITY COLLEGE**
**SCHEDULE OF MEDICAL BENEFITS**
**PREFERRED PROVIDER ORGANIZATION (PPO) PLAN 1**
**HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**
**Effective Date: July 1, 2020**
**Benefit Year: The 12 month period beginning each January 1 and ending each December 31.**

**Network Benefits** are provided by a network provider (except as otherwise provided by this SPD), and may require prior certification with the Benefit Administrator (except in a medical emergency). For a directory of Priority Health network providers, call the Customer Service Department at **616 956-1954 or 800 956-1954** or access the Find a Doctor tool on the Priority Health website at priorityhealth.com.

**Non-Network Benefits** are provided by non-network providers. Services may require the satisfaction of deductibles and coinsurance amounts, and are subject to reasonable and customary charges. Some benefits must be prior certified with the Benefit Administrator (except in a medical emergency).

**Prior Certification:** Prior certification is required for all inpatient hospital or facility services. 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 our Behavioral Health Department as soon as possible for assistance. Call our Behavioral Health department at **616 464-8500** or **800 673-8043** for assistance. You do not need prior approval from Priority Health 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
- Hospice Care
- Transplants
- 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.

**Deductibles:**

The deductible is the dollar amount of covered services you must incur during the plan year before benefits will be paid. The deductible is applicable to all covered services except:

- Network preventive health services that are listed in Priority Health's preventive health care guidelines.
- Network routine maternity services provided in your physician's office (deductible **will** apply to delivery, facility charges and anesthesia charges associated with the delivery).
- Certain drugs set forth in IRS Notice 2004-50 and Notice 2019-45. Applicable copayments will apply.
- Certain network 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.

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 the family deductible below must be met. The family deductible can be satisfied by only one family member or by any combination of family members.

The network and non-network deductible are calculated separately. You must meet the deductible at the network benefit level before benefits will be paid for services you seek under the network benefits. If you choose to use the non-network benefits, you must meet the deductible at the non-network benefits level before benefits will be paid for services you seek under the non-network benefits. Network deductible amounts do not apply to non-network deductible amounts, nor do non-network deductible amounts apply to network deductible amounts.

The deductible amounts renew each benefit year. This plan does not carry over any deductible amounts incurred in the prior benefit year.

The network benefits deductible will include any monies paid for covered pharmacy services.

Notwithstanding the above, the following costs shall not apply towards the deductible: Non-covered services; services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); and any amounts paid by participants for non-network benefits that exceed reasonable and customary.

**Out-of-Pocket Limits:**

The out-of-pocket limit limits the total amount of covered expenses that you or your covered dependents will pay during a benefit year. The network and out-of-network out-of-pocket limits are calculated separately. Once the applicable out-of-pocket limit for the network benefits level is met, all further medical and pharmacy covered services for that benefit year for network benefits will be paid at 100% of network's contracted rate. Once the applicable out-of-pocket for the non-network benefits level is met, all further medical covered services for that benefit year for non-network benefits will be paid at 100% of the lesser of billed charges or reasonable and customary charges.

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 the family out-of-pocket limit below must be met. The family out-of-pocket limit can be satisfied by only one family member or by any combination of family members.

Notwithstanding the above, the following out-of-pocket costs do not apply towards the out-of-pocket limit: Expenses for non-covered services, services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); and costs paid by participants to provider for non-network 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 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 BENEFIT | NON-NETWORK BENEFIT |
|---|---|---|
| **Deductibles** | $2,000 per individual;<br>$4,000 per family per benefit year | $4,000 per individual;<br>$8,000 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 Limits** (Includes deductible, coinsurance and copayment expenses.) | $3,000 per individual;<br>$6,000 per family per benefit year | $6,000 per individual;<br>$12,000 per family per benefit year |
| **BENEFITS** | **NETWORK BENEFIT** | **NON-NETWORK BENEFIT** |
| **Preventive Health Care Services -** Preventive Health Care Services are described in Priority Health's Preventive Health Care Guidelines available on [priorityhealth.com](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. |
| **Routine Laboratory Tests, Screening and Counseling** | 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. |
| **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. |

| BENEFITS | NETWORK BENEFIT | NON-NETWORK BENEFIT |
|---|---|---|
| **Medical Office Services** | | |
| **Office/Home Visits and Consultations** (Includes visits *not* listed in Priority Health's Preventive Health Care Guidelines or routine maternity services.) | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Virtual Visits** | 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 Services** (Including allergy testing, evaluations 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 or freestanding facility.) | Covered at 80% after deductible. | Covered at 60% 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 80% after deductible. | Covered at 60% after deductible. |
| **Maternity Services** | Routine prenatal and postnatal visits are covered at 100%, deductible waived under the Preventive Health Care Services benefits above.<br>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 80% after deductible. | Not covered. |
| **Dietitian Services** (Other than as provided in Priority Health's Preventive Health Care Guidelines.) | Covered at 80% after deductible up to a maximum of six visits per benefit year. | Not covered. |
| **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**<br>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. |
| **Inpatient Professional and Surgical Charges**<br>*Evaluation and Management for Inpatient and Observation services covered at the Network rate when at a network facility. | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Human Organ Tissue Transplants**<br>Covered only with prior certification from Benefit Administrator. | Covered at 80% after deductible. | Covered at 60% after deductible. |

| BENEFITS | NETWORK BENEFIT | NON-NETWORK BENEFIT |
|---|---|---|
| **Hospital Services (continued)** | | |
| **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.) | 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. |
| **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. |
| **Certain Surgeries and Treatments**<br>• **Reconstructive Surgery**: blepharoplasty of upper eyelids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia<br>• **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.<br>• **Varicose Veins Treatments**<br>• **Sleep Apnea Treatment Procedures** | Covered at 80% after deductible.<br><br>*Prior certification required for panniculectomy, rhinoplasty and septorhinoplasty.<br><br>**Bariatric surgery is not covered.** | Covered at 60% after deductible.<br><br>*Prior certification required for panniculectomy, rhinoplasty and septorhinoplasty.<br><br>**Bariatric surgery is not covered.** |
| 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** | Covered at 80% after deductible. | Paid at the Network Benefit Level. Reasonable and customary limitations apply. |
| **Ambulance Services** | Covered at 80% after deductible. | Paid at the Network Benefit Level. Reasonable and customary limitations apply. |
| **Urgent Care Facility Services** | Covered at 80% after deductible. | Covered at 60% after deductible. |

| BENEFITS | NETWORK BENEFIT | NON-NETWORK BENEFIT |
|---|---|---|
| **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 residential treatment and partial hospitalization.)<br>Prior certification required except in emergencies. | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Outpatient Mental Health Services**<br>Face-to-face, telephonic, or through secure electronic portal.<br>(Including medication management visits.) | The first three visits (within 90 days of discharge) from a network hospital for mental health inpatient care are covered at 100% after deductible.<br>Covered at 80% after deductible, for all other visits. | Covered at 60% after deductible. |
| **Outpatient Substance Use Disorder Services**<br>Face-to-face, telephonic, or through secure electronic portal.<br>(Including medication management visits.) | 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 80% after deductible. | Covered at 60% after deductible. |
| **Vasectomy**<br>Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery. | 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.<br><br>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 Network/Non-Network Benefit) | Covered at 80% after deductible up to a benefit maximum of 60 visits per benefit year. | Covered at 60% after deductible up to a benefit maximum of 60 visits per benefit year. |
| **Speech Therapy** (Combined Network/Non-Network Benefit) | Covered at 80% after deductible up to a benefit maximum of 60 visits per benefit year. | Covered at 60% after deductible up to a benefit maximum of 60 visits per benefit year. |
| **Cardiac Rehabilitation and Pulmonary Rehabilitation** (Combined Network/Non-Network Benefit) | Covered at 80% after deductible up to a benefit maximum of 60 visits per benefit year. | Covered at 60% after deductible up to a benefit maximum of 60 visits per benefit year. |
| **Chiropractic Services** (Combined Network/Non-Network Benefit) (Includes maintenance care.) | Covered at 80% after deductible up to a benefit maximum of 40 visits per benefit year. | Covered at 60% after deductible up to a benefit maximum of 40 visits per benefit year. |

| BENEFITS | NETWORK BENEFIT | NON-NETWORK BENEFIT |
|---|---|---|
| **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.** Prior certification required for ABA. | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Other Services** | | |
| **Durable Medical Equipment**<br>Prior certification is required for charges over $1,000. | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Prosthetic & Orthotic/Support Devices**<br>Prior certification is required for charges over $1,000. | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Temporomandibular Joint Syndrome (TMJS) Treatment** | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Orthognathic Treatment** | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Non-Hospital Facility Services –**<br>Including skilled nursing care services received in a:<br>• Skilled Nursing Care Facility<br>• Subacute Facility<br>• Inpatient Rehabilitation Facilities Treatment<br>Prior certification required. | 80% coverage up to a maximum of 120 days per benefit year after deductible. | 60% coverage up to a maximum of 120 days per benefit year after deductible. |
| **Home Health Services and Infusion Therapy** (Excluding rehabilitative medicine.) Prior certification required. | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Hospice.** Prior certification required. | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Radiation Therapy and Chemotherapy** | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Hemodialysis** | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Private Duty Nursing** | Covered at 80% after deductible. | Covered at 60% after deductible. |
| **Pharmacy Benefits – Participating Pharmacies** | | |
| **Prescription Drugs - Managed Formulary**<br>Includes disposable needles and syringes for diabetics.<br>Includes infertility and sexual dysfunction medications.<br>Any medications provided in Priority Health's Preventive Health Care Guidelines, including certain women's prescribed contraceptive methods are covered at 100%, copayments waived.<br>Brand-name contraceptives (except those without a generic equivalent) are subject to applicable deductible and copayments.<br>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.<br><br><u>Retail Pharmacy (up to 31 days):</u><br>Generic Drugs: $15 copayment<br>Preferred Brand Name Drugs: $50 copayment<br>Non-Preferred Brand Name Drugs: $80 copayment<br><br><u>Mail Service Program (up to 90 days):</u><br>Generic Drugs: $30 copayment<br>Preferred Brand Name Drugs: $100 copayment<br>Non-Preferred Brand Name Drugs: $160 copayment<br><br>For information about the mail order program, visit their website at <u>express-scripts.com</u>.<br><br>Certain drugs set forth in IRS Notice 2004-50 and Notice 2019-45 shall be covered prior to satisfying your deductible. Copayments waived. | |

| BENEFITS | NETWORK BENEFIT | NON-NETWORK BENEFIT |
|---|---|---|
| **Hearing Benefits** | | |
| **Hearing Care Services** | Covered at 100% up to a maximum benefit of $500 per ear per 36 consecutive months per person. Limited to one hearing evaluation test, one audiometric examination and one basic hearing aid per ear. Deductible applies. | |
| **Coverage Information** | | |
| **Waiting Period Requirement** | First of the month following date of hire. | |
| **Full-Time Employee** | 30 hours worked per week. | |
| **Dependent Children** | Covered up to the end of the year in which they turn age 26. Age 26 and older covered if mentally or physically incapacitated dependent. | |
| **Motor Vehicle Injuries** | Coordinated with motor vehicle insurance. | |
| **Motorcycle Injuries** | Coordinated with motorcycle vehicle insurance. | |
| **Travel Network Benefit** | | |
| Submit Claims for the Travel Network to:<br><br>**Cigna**<br>**PO Box 188061**<br>**Chattanooga, TN 37422-8061** | When medical care is needed while outside the Priority Health service area, benefits will be paid at the network level when you use a Cigna PPO Provider. The directory is available on the Cigna website at Cigna.com as part of the Find a Doctor, Dentist or Facility tool or by calling the Cigna Customer Service Department at **833 300-3628.** | |

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.

**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.

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.

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.)