Grand Valley State University: PPO - Standard Plan

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Subscriber/Dependent | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **PriorityHealth.com** or by calling **1-800-956-1954**.

Important Questions	Answers	Why this Matters
What is the overall deductible?	For network providers **$250** person / **$500** family For non-network providers **$500** person / **$1,000** family The network benefits deductible doesn't apply to preventive care or certain services subject to flat dollar co-pays. The amounts calculated toward the non-network benefits deductible apply to the network benefits deductible. The network benefits also apply to the non-network benefits deductible. Amounts you pay toward the deductible do not count toward any co-insurance maximums.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For network providers **$7,150** person / **$14,300** family For non-network providers **$7,150** person / **$14,300** family Your plan also has a co-insurance maximum: For network providers **$1,000** person/ **$2,000** family For non-network providers **$2,500** person/ **$5,000** family The co-insurance maximum limits the total amount of co-insurance you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the out-of-pocket limit. The amounts calculated toward the non-network benefits co-insurance maximum and out-of-pocket limit apply to the network benefits co-insurance maximum and out-of-pocket limit. The amounts calculated toward the network benefits co-insurance maximum and out-of-pocket limit also apply to the amounts calculated toward the non-network benefits co-insurance maximum and out-of-pocket limit.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit and any co-pays and prior certification penalties. See plan documents for additional services that may not be included in the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **PriorityHealth.com or call 1-800-956-1954** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-956-1954** or visit us at **PriorityHealth.com**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform or www.cciio.cms.gov** or call 1-800-956-1954 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.
- You may be able to pay your **deductible** and **Co-insurance** using money from a Health Reimbursement Account (HRA) or Flexible Spending Accounts (FSA).

Common Medical Events	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/ visit	30% co-insurance/ visit	In-network benefits coverage includes services provided face-to-face, telephonically, or through secure electronic portal. Out-of-network benefits coverage includes face-to-face visits only. See the Schedule of Benefits for a complete list of certain surgeries and treatments. Prior certification may be required. Penalty applies if not prior certified. Retail service center services are covered at reasonable and customary charges. Dietitian services include visits *not* listed in Priority Health's Preventive Health Care Guidelines. These services are limited to 6 visits per contract year. Prior certification is required for all treatments of Autism Spectrum Disorder. See Habilitation Services below for additional information. $20 co-pay/ visit for chiropractic services provided by network providers. Covered up to a combined contract year maximum of 20 visits. 30% co insurance / visit for chiropractic provided by a non-network providers. Covered up to a combined contract year maximum of 20 visits. Temporomandibular Joint Function (TMJ) treatment covered up to a combined lifetime maximum benefit of $1,000.
	Specialist visit	$20 co-pay/ visit	30% co-insurance/ visit	
	Other practitioner office visit	•$20 co-pay/ visit for eCare visits •$20 co-pay/ visit for evaluation/management services only at retail service centers •10% co-insurance/ visit for dietitian services •No charge for allergy testing, serum & injections •10% co-insurance/ visit for family planning/ infertility services •10% co-insurance for Temporomandibular Joint Function (TMJ) treatment •50% coverage for Orthognathic treatment •10% co-insurance for each certain surgery or morbid obesity treatment	•eCare visits not covered •Evaluation/management services only at retail service centers covered at the network benefit level •30% co-insurance/ visit for dietitian services •30% co-insurance/ visit for allergy testing, serum & injections •30% co-insurance/ visit for family planning/infertility services •30% co-insurance for Temporomandibular Joint Function (TMJ) treatment •50% coverage for Orthognathic treatment •30% co-insurance for each certain surgery or morbid obesity treatment	
	Preventive care/screening/ immunization	No charge	30% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Deductible does not apply. Preventive eye exam and Glaucoma testing covered up to a combined maximum of one exam every two years.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	30% co-insurance	No charge for diagnostic testing preformed in a physician's office.
	Imaging (CT/PET scans, MRIs)	10% co-insurance	30% co-insurance	Prior certification required for certain radiology examinations. Penalty applies if not prior certified. No charge for imaging services performed in a physician's office

Common Medical Events	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvscaremark.com	Generic drugs	$4 co-pay / retail prescription $8 co-pay / mail-order prescription	$4 co-pay / retail prescription $8 co-pay / mail-order prescription	**Prescription Drug – Administered by CVS Caremark** Includes coverage for specified drugs and medication required by PPACA. If your prescription drug coverage is provided by a plan other than Priority Health, your out-of-pocket costs for prescription drugs covered under that plan will also track to the Out-of-Pocket Limit specified in your Schedule of Benefits, if applicable. If the issuer of the prescription drug plan does not provide timely updates or provides inaccurate information related to your out-of-pocket expense for drugs covered under that plan, Priority Health will not be responsible for reprocessing claims upon receipt of delayed or corrected information. Retail Pharmacy 90 Day Program (up to 90 days): Generic Drugs: $12 copayment Preferred Brand Name Drugs: $60 copayment Non-Preferred Brand Name Drugs: $120 copayment
	Preferred brand drugs	$20 co-pay / retail prescription $40 co-pay / mail order prescription	$20 co-pay / retail prescription $40 co-pay / mail order prescription	
	Non-preferred brand drugs	$40 co-pay / retail prescription $80 co-pay / mail order prescription	$40 co-pay / retail prescription $80 co-pay / mail order prescription	
	Preferred specialty drugs	Contact CVS Caremark	Contact CVS Caremark	----------none----------
	Non-Preferred specialty drugs	Contact CVS Caremark	Contact CVS Caremark	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance/ visit	30% co-insurance/ visit	Including outpatient care, observation care and ambulatory surgery center care. Prior certification may be required. See the Schedule of Benefits for a complete list of certain surgeries and treatments. Prior certification is required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Penalty applies if not prior certified. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fees	10% co-insurance/ visit	30% co-insurance/ visit	
If you need immediate medical attention	Emergency room services	$50 co-pay/ visit	Covered at the network benefit level	Co-pay waived if you become confined in a Hospital as an inpatient.
	Emergency medical transportation	10% co-insurance	Covered at the network benefit level	----------none----------
	Urgent care	$20 co-pay/ visit	30% co-insurance/ visit	Co-pay applies to all urgent care visits.

Common Medical Events	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance/ visit	30% co-insurance/ visit	Prior certification is required at least 5 working days in advance, 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. Notification must be provided for all admissions following emergency room care. Penalty applies if not prior certified. See the Schedule of Benefits for a complete list of certain surgeries and treatments. Prior certification is required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Penalty applies if not prior certified. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fee	10% co-insurance/ visit	30% co-insurance/ visit	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/ visit	30% co-insurance/ visit	Including medication management visits.
	Mental/Behavioral health inpatient services	10% co-insurance/ visit	30% co-insurance/ visit	Including Residential Treatment and partial hospitalization. Except in an emergency, prior certification required. Penalty applies if not prior certified
	Substance use disorder outpatient services	$20 co-pay/ visit	30% co-insurance/ visit	Including medication management visits.
	Substance use disorder inpatient services	10% co-insurance/ visit	30% co-insurance/ visit	Including subacute, Residential Treatment and partial hospitalization. Except in an emergency, prior certification required. Penalty applies if not prior certified
If you are pregnant	Routine prenatal and postnatal care	No charge	30% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. 10% co-insurance for approved maternity education classes provided by a network provider. Maternity education classes provided by a non-network provider are not covered. Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.
	Delivery and all inpatient services	10% co-insurance/ visit	30% co-insurance/ visit	Deductible applies to facility charges for delivery.

Common Medical Events	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you need help recovering or have other special health needs	Home health care	$20 co-pay/ visit	$20 co-pay/ visit	Excluding rehabilitation and habilitation services. Prior certification required. Home health care services are limited to a combined 60 visits per contract year. Rehabilitation and habilitation services provided in the home are subject to the limitations of the Rehabilitation Services and Habilitation Services benefits described below.
	Rehabilitation services These services are *not* for the treatment of Autism Spectrum Disorder	10% co-insurance/ visit	30% co-insurance/ visit	Physical and occupational therapy limited to a combined 30 visits per contract year. Speech therapy limited to a combined 30 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits per contract year.
	Habilitation services for treatment of Autism Spectrum Disorder ***only***	10% co-insurance/ visit	30% co-insurance/ visit	Prior certification required for Applied Behavioral Analysis. Physical, occupational, and speech therapy and Applied Behavioral Analysis (ABA) are covered up to a combined 135 days per contract year for the treatment of Autism Spectrum Disorder only and are available for children and adolescents through the age of 18 only.
	Habilitation services *not* for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered
	Skilled nursing care	10% co-insurance/ visit	30% co-insurance/ visit	Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 120 days per contract year. Prior certification required.
	Durable medical equipment (DME)	10% co-insurance/ visit	30% co-insurance/ visit	Including rental, purchase or repair. Prior certification required for equipment over $1,000. Surgical bras after mastectomy limited to 4 bras per contract year. Compression stockings limited to 12 pairs per contract year.
	Prosthetics & orthotics	10% co-insurance/ visit	30% co-insurance/ visit	
	Hospice service	10% co-insurance/ visit	10% co-insurance/ visit	This benefit applies to hospice services provided in the home only. Any hospice services provided in a facility will be subject to the appropriate facility benefit. Prior certification required.
If your child needs dental or eye care	Eye exam	See plan documents	See plan documents	See plan documents
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Habilitation services not for the treatment of Autism Spectrum Disorder
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Emergency services provided outside the U.S.
- Hearing aids
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-956-1954. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Priority Health at 1-800-956-1954 or visit www.priorityhealth.com;
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or
- The Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or **DIFS-HICAP@Michigan.gov**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefit it provides.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

NOTE: These examples demonstrate possible costs under Subscriber only coverage. If you have Subscriber/Dependent coverage, your costs may be different.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,340
- **Patient pays** $1,110

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Co-pays	$0
Co-insurance	$710
Limits or exclusions	$150
Total	**$1,110**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,480
- **Patient pays** $920

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Co-pays	$360
Co-insurance	$230
Limits or exclusions	$80
Total	**$920**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-528-8762.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-528-8762.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-528-8762.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-528-8762

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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