GRAND VALLEY STATE UNIVERSITY
SCHEDULE OF MEDICAL BENEFITS
Preferred Provider Organization (PPO) Plan – Retiree Plan
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 a network provider (except as otherwise provided by the summary plan description (SPD)), 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 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 prioritynealth.com. For a current status of Upper Peninsula Health Plan (UPHP) Network providers, visit their website at www.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. 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
- Pain Management Services
- Gender Dysphoria or Reassignment Services
- Transplants
- Advanced Diagnostic Imaging Services
- Prosthetic Devices over $1,000
- Morbid Obesity Treatment

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 and coinsurance maximum amounts apply to non-network deductible and coinsurance maximum amounts, and non-network deductible and coinsurance maximum amounts apply to network deductible and coinsurance maximum 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 SPD. 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 SPD and any applicable amendments to the plan.

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Deductibles	$250 per individual; $500 per family per plan year	$500 per individual; $1,000 per family per plan year
Benefit Percentage Rate	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.
Coinsurance Maximums	$1,000 per individual; $2,000 per family per plan year. All services apply to the maximum except as noted. ***Please note the deductible does not apply to the coinsurance maximum.***	$2,500 per individual; $5,000 per family per plan year. All services apply to the maximum except as noted. ***Please note the deductible does not apply to the coinsurance maximum.***
Out-of-Pocket Limit (Annual out-of-pocket costs for health care, including deductibles, co-insurance and co-payments, are limited under the ACA.)	$8,700 per individual; $17,400 per family per plan year.	$8,700 per individual; $17,400 per family per plan year.
Reduction of Benefits Penalty	$300 penalty if not prior certified.	

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 in the member center the website at prioritythealth.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 100%. Deductible does not apply.	Covered at 70% after deductible.
Women's Preventive Health Care Services	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
Routine Laboratory Tests, Screening and Counseling	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
PSA Tests, Prostate Exams and Colon/Rectal Screenings	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
Well Child and Adolescent Care, Screening and Assessments	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
Immunizations	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
Routine Eye Exam and Glaucoma Testing* (Combined Network/Non-Network Benefit.)	Covered 100%. Deductible does not apply. One exam each two years.	Covered at 70% after deductible up to a maximum benefit of $40. One exam each two years.
*This is a PriorityVision benefit administered by EyeMed. For a complete list of network providers near you, use the online Find a Doctor directory at prioritythealth.com and choose "PriorityVision", or call the Priority Health Customer Service Department at **877 572-4001**.		
Medical Office Services		
Office/Home Visits and Consultations (Includes visits *not* listed in Priority Health's Preventive Health Care Guidelines or routine maternity services.) Face-to-face and telehealth (includes telephonic and telemedicine.) (Including medication management visits.)	$20 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Virtual Care Services (E.g. Spectrum Health or MDLive acute virtual care providers.)	$20 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Retail Health Clinic Visits (Located within the United States.)	$20 copayment per visit for evaluation and management services only. Deductible does not apply.	$20 copayment per visit for reasonable and customary charges for evaluation and management services only. Deductible does not apply.
Office Surgery (Performed in physician's office.)	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
Office Injections (Performed in physician's office.)	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
Allergy Office Services (Including allergy testing and injections, including serum costs) (Performed in physician's office.)	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office.)	Covered 100%. Deductible does not apply.	Covered at 70% after deductible.
Advanced Diagnostic Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies (Performed in physician's office.) Prior certification required.	Covered 100%. Deductible does not apply. $300 penalty if not prior certified.	Covered at 70% after deductible. $300 penalty if not prior certified.
Obstetrical Services by Physician (Including prenatal and postnatal care.)	Routine prenatal visits are covered at 100%, deductible waived under the Preventive Health Care Services benefits above. See the Hospital Services section for facility, delivery and nursery service benefits.	Covered at 70% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Office Services (continued)		
Maternity Education Classes	Attendance at an approved maternity education program is covered at 90% after deductible	Not covered.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	Covered at 90% after deductible.	Covered at 70% after deductible.
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 90% after deductible. $300 penalty if not prior certified.	Covered at 70% after deductible. $300 penalty if not prior certified.
Inpatient Professional and Surgical Charges 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.
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 90% after deductible.	Approved transplants are covered at the network benefit level.
Travel, Meals and Lodging Expenses Associated with an Organ Transplant (Combined Network/Non-Network Benefit.) Limitations apply.	Covered at 90% after deductible up to a maximum benefit of $10,000.	Travel, Meals and Lodging Expenses associated with an approved transplant are covered at the network benefit level.
Approved Clinical Trial Expenses (Includes routine expenses related to an approved clinical trials.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center or freestanding facility charges.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 90% after deductible.	Covered at 70% after deductible.
Obstetrical Services in Hospital (Includes delivery, facility and anesthesia services.)	Covered at 90% after deductible.	Covered at 70% after deductible.
Hospital and Freestanding Facility Diagnostic Laboratory & Radiology Services	Covered at 90% after deductible.	Covered at 70% after deductible.
Hospital and Freestanding Facility Advanced Diagnostic Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies Prior certification required.	Covered at 90% after deductible. $300 penalty if not prior certified.	Covered at 70% after deductible. $300 penalty 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 90% after deductible. Certain surgeries and treatments are covered only if medically/necessary. In addition, age limitations may apply to certain surgeries and treatments.	Covered at 70% after deductible. Certain surgeries and treatments are covered only if medically/necessary. In addition, age limitations may apply to certain surgeries and treatments.
Morbid Obesity Treatment • Gastric or intestinal bypasses. • Stomach Stapling. • Lap Band. • Charges for diagnostic services Prior approval required.	Covered at 90% after deductible. $300 penalty if not prior certified.	Covered at 70% after deductible. $300 penalty if not prior certified.
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	$50 copayment per visit. Deductible does not apply.	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 does not apply.		
Ambulance Services	Covered at 90% after deductible.	Paid at the Network Benefit Level. Reasonable and customary limitations apply.
Urgent Care Facility Services	$20 copayment per visit. Deductible does not apply.	Covered at 70% 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 90% after deductible. $300 if not prior certified.	Covered at 70% after deductible. $300 if not prior certified.
Outpatient Office Services for Mental Health & Substance Abuse Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits.)	$20 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Family Planning and Reproductive Services		
Infertility Counseling & Treatment Covered for diagnosis and treatment of underlying cause only. Limitations and exclusions apply.	Paid at the applicable benefit level of the service rendered.	Covered at 70% after deductible.
Vasectomy Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.	Covered at 90% after deductible.	Covered at 70% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Family Planning and Reproductive Services (continued)		
Tubal Ligation/Tubal Obstructive Procedures (Included as part of the Women's Preventive Health Services benefits.)	Covered at 100%, deductible does not apply 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 70% 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 100%. Deductible does not apply.	Covered at 70% after deductible.
Gender Dysphoria or Reassignment Services Prior approval required.	Covered at 90% after deductible.	Covered at 70% after deductible.
Rehabilitative Medicine Services – Not related to Autism Treatment		
Physical and Occupational Therapy (Including aquatic, massage and vision therapy.) (Combined Network/Non-Network Benefit.)	Covered at 90% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 70% after deductible up to a benefit maximum of 30 visits per plan year. *
Speech Therapy (Combined Network/Non-Network Benefit.)	Covered at 90% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 70% after deductible up to a benefit maximum of 30 visits per plan year. *
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Network/Non-Network Benefit.)	Covered at 90% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 70% after deductible up to a benefit maximum of 30 visits per plan year. *
*Visits will be reviewed for additional visit allowance based on medical necessity after reaching the 30 visit maximum 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. (Combined Network/Non-Network Benefit.)	Covered at 90% after deductible up to a benefit maximum of 135 days per plan year. Prior Approval required for ABA.	Covered at 70% after deductible up to a benefit maximum of 135 days per plan year. Prior Approval required for ABA.
Other Services		
Durable Medical Equipment Prior certification is required for charges over $1,000.	Covered at 90% after deductible.	Covered at 70% after deductible.
• Surgical bras after mastectomy: Limited to 4 bras per plan year. • Compression Stockings: Limited to 12 pairs per plan year.		
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 90% after deductible.	Covered at 70% after deductible.
Wigs, Toupees and Hairpieces Covered when prescribed by a physician for a medical condition.	Covered at 90% after deductible.	Covered at 70% after deductible.
Chiropractic Services and Osteopathic Manipulation Therapy Visits (Combined Network/Non-Network Benefit.) (Including maintenance care and massage therapy.)	$20 copayment per visit up to a benefit maximum of 30 visits per plan year. Deductible does not apply.	Covered at 70% after deductible up to a benefit maximum of 30 visits per plan year.
Temporomandibular Joint Syndrome (TMJS) Treatment (Combined Network/Non-Network Benefit.)	Covered at 90% after deductible up to a lifetime maximum benefit of $1,000.	Covered at 70% after deductible up to a lifetime maximum benefit of $1,000.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (continued)		
Orthognathic Surgery & Treatment	Not covered.	Not covered.
Cochlear Implants	Not covered.	Not covered.
Skilled Nursing, Extended Care, Subacute and Inpatient Rehabilitation Facilities (Combined Network/Non-Network Benefit.) Prior certification required.	Covered at 90% after deductible up to a maximum of 120 days per plan year.	Covered at 70% after deductible up to a maximum of 120 days per plan year.
Home Health Services (Combined Network/Non-Network Benefit.) Prior certification required.	$20 copayment per visit up to a maximum benefit of 60 visits per plan year. Deductible applies.	$20 copayment per visit up to a maximum benefit of 60 visits per plan year. Deductible applies.
Hospice Services (Includes hospice, bereavement and respite services.)	Covered at 90% after deductible.	Covered at 90% after deductible.
Radiation Therapy and Chemotherapy	Covered at 90% after deductible.	Covered at 70% after deductible.
Hemodialysis	Covered at 90% after deductible.	Covered at 70% after deductible.
Private Duty Nursing (Combined Network/Non-Network Benefit.)	$20 copayment per visit up to a maximum benefit of 60 visits per plan year. Deductible applies.	$20 copayment per visit up to a maximum benefit of 60 visits per plan year. Deductible applies.
Hearing Services (Combined Network/Non-Network Benefit.)	Covered at 90% after deductible. $750 maximum benefit per ear every 36 months for hearing aids.	Covered at 70% after deductible. $750 maximum benefit per ear every 36 months for hearing aids.
Eye Care Services Covered for treatment of medical conditions and diseases of the eye only. Vision supplies are not covered.	Paid at the applicable benefit level of the service rendered.	Covered at 70% after deductible.
Travel Network Benefit		
Submit Claims for the Travel Network to: **Cigna** **PO Box 188061** **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.**	
Coverage Information		
Retirees	Eligible employees who retire under the employer's formal retirement plan until they reach age 65.	
Household Member	A household member may qualify as a covered dependent upon meeting the criteria as set-forth in the *Eligibility* section of the plan.	
Dependent Children	Covered up to the end of the month in which they turn age 26 or up to the date they turn age 27 if enrolled in a qualified course of study. Over age 26 if mentally or physically incapacitated dependent.	
Motor Vehicle Injuries	Are not covered except in limited circumstances.	
Motorcycle Injuries	Coordinated with any available 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.

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 plan year, except as described below. If the individual coinsurance maximum is reached during a plan year, the benefit percentage is 100% of covered expenses incurred by that person for the rest of the plan 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 plan 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;
- Penalties, legal fees and interest charged by a provider;
- Expenses incurred as a result of failure to comply with prior authorization requirements for hospital confinements; and
- Deductibles.

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, 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% of covered expenses 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 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.)