

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
**Grand Valley State University: Standard PPO**

**Coverage Period: 01/01/2021 - 12/31/2021**  
**Coverage for: Subscriber/Dependent | Plan Type: PPO**



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **Note:** Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**. For more information about your coverage or to get a copy of the complete terms of coverage, visit us at PriorityHealth.com or call 1-800-956-1954. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-956-1954 to request a copy.

Important Questions	Answers	Why this Matters
<b>What is the overall deductible?</b>	For <u>network providers</u> \$250 person / \$500 family For <u>non-network providers</u> \$500 person / \$1,000 family Amounts calculated toward the non-network benefits deductible apply to the network benefits deductible. The network benefits deductible also apply to the non-network benefits deductible. Amounts you pay toward the deductible do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes, the network benefits <u>deductible</u> doesn't apply to <u>preventive care</u> , services subject to flat dollar <u>co-pays</u> and prescription drugs.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Yes. For <u>network providers</u> \$8,550 person / \$17,100 family For <u>non-network providers</u> \$8,550 person / \$17,100 family Your plan also has a co-insurance maximum. For <u>network providers</u> \$1,000 person / \$2,000 family For <u>non-network providers</u> \$2,500 person / \$5,000 family The co-insurance maximum limits the total amount of <u>co-insurance</u> you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the <u>out-of-pocket limit</u> . The <u>out-of-pocket limit</u> for each benefit level is calculated separately.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and prior certification penalties.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See PriorityHealth.com or call 1-1-800-956-1954 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 co-pay/ visit	30% co-insurance/ visit	<p>Network benefit level deductible does not apply to services subject to flat dollar co-pays.</p> <p>Temporomandibular Joint Function (TMJ) treatment covered up to combined lifetime maximum of \$1000.</p> <p>\$20 co-pay/ visit for chiropractic and osteopathic manipulation services provided by a network provided. Covered up to a combined maximum of 30 visits per contract year.</p> <p>30% co-insurance/ visit for chiropractic and osteopathic manipulation services provided by a non-network provided. Covered up to a combined maximum of 30 visits per contract year.</p>
	Specialist visit	\$20 co-pay/ visit	30% co-insurance/ visit	
	Other practitioner office visit	<ul style="list-style-type: none"> <li>•\$20 co-pay/ visit for evaluation/ management services only at retail health clinics</li> <li>•Family planning/ infertility services covered</li> <li>•10% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> <li>•50% co-insurance for Orthognathic surgery</li> </ul>	<ul style="list-style-type: none"> <li>•Evaluation/management services only at retail health clinics covered at the network benefit level</li> <li>•30% co-insurance/ visit for family planning/ infertility services</li> <li>•30% co-insurance for Temporomandibular Joint Function (TMJ) treatment</li> <li>•50% co-insurance for Orthognathic surgery</li> </ul>	
	Preventive care/screening/immunization	No charge	30% co-insurance/ visit	
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	10% co-insurance	30% co-insurance	<p>Prior Certification required for genetic testing.</p> <p>No charge for diagnostic testing services received in a network physician's office, deductible does not apply.</p>
	Imaging (CT/PET scans, MRIs)	10% co-insurance	30% co-insurance	<p>Prior Certification required for certain radiology examinations.</p> <p>No charge for advanced imaging services received in a network physician's office, deductible does not apply.</p> <p>Penalty applies if not prior certified.</p>

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi">https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi</a>	Generic drugs (Tier 1)	\$4 co-pay/ retail prescription \$8 co-pay/ mail order prescription	Not covered	Prescription Drugs – Administered by CVS Caremark More information about prescription drug coverage is available at <a href="http://www.caremark.com">www.caremark.com</a> or by calling (888) 549-5789. 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, 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.
	Preferred brand drugs (Tier 2)	\$20 co-pay/ retail prescription \$40 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	\$40 co-pay/ retail prescription \$80 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs (Tier 4)	Contact CVS Caremark	Not covered	-----none-----
	Non-Preferred specialty drugs (Tier 5)	Contact CVS Caremark	Not covered	
<b>If you have outpatient surgery</b>	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. Prior Certification is required for bariatric surgery. Penalty applies if not prior certified.
	Physician/surgeon fees	10% co-insurance/ visit	30% co-insurance/ visit	
<b>If you need immediate medical attention</b>	Emergency room services	\$50 co-pay/ visit	Covered at the network benefit level; R&C limitations apply	Co-pay waived if you become confined in a Hospital as an inpatient. Network benefit level deductible does not apply.
	Emergency medical transportation	10% co-insurance	Covered at the network benefit level; R&C limitations apply	-----none-----
	Urgent care	\$20 co-pay/ visit	30% co-insurance/ visit	Co-pay applies to all urgent care visits. Network benefit level deductible does not apply.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	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. Penalty applies if not prior certified.
	Physician/surgeon fee	10% co-insurance/ visit	30% co-insurance/ visit	Notification must be provided for all admissions following emergency room care. Prior Certification is required for bariatric surgery. Penalty applies if not prior certified.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Mental/Behavioral health outpatient services	\$20 co-pay/ visit	30% co-insurance/ visit	Including medication management visits. Network benefit level deductible does not apply.
	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. Network benefit level deductible does not apply.
	Substance use disorder 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.
<b>If you are pregnant</b>	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 when 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 to physician office services for complications of pregnancy.
	Delivery professional fees	10% co-insurance/ visit	30% co-insurance/ visit	-----none-----
	Delivery facility fees	10% co-insurance/ visit	30% co-insurance/ visit	-----none-----

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	Home health care	\$20 co-pay/ visit	\$20 co-pay/ visit	Excluding rehabilitation and habilitation services. Home health care services limited to a combined 60 visits per contract year. Prior Certification required.
	Rehabilitation services <i>not</i> 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 <i>only</i>	10% co-insurance/ visit	30% co-insurance/ visit	Prior Certification required for Applied Behavior Analysis (ABA). Covered services include Physical, Occupational, Speech Therapy and Applied Behavior Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service.
	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, except for hospice care.
	Durable medical equipment (DME)	10% co-insurance/ visit	10% co-insurance/ visit	Including rental, purchase or repair. Prior Certification required for equipment over \$1,000, all rentals and all shoe inserts.
	Prosthetics & orthotics	10% co-insurance/ visit	30% co-insurance/ visit	Surgical bras after mastectomy: Limited to 4 bras per contract year. Compression Stockings: Limited to 12 pairs per contract year.
	Hospice service	10% co-insurance/ visit	10% co-insurance/ visit	-----none-----
<b>If your child needs dental or eye care</b>	Child eye exam	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered
	Child dental check-up	Not covered	Not covered	Not covered

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)

- Bariatric surgery
- Chiropractic care
- 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:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov); the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov); or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Priority Health at 1-800-956-1954 or [www.priorityhealth.com](http://www.priorityhealth.com); the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov).

### Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-956-1954.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-956-1954.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-956-1954.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-956-1954.

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

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments, and co-insurance) and excluded services under this plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Co-payments	\$100
Co-insurance	\$2,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,660</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,00
Co-payments	\$1,500
Co-insurance	\$900
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,460</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist co-payment</u>	\$50
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Co-payments	\$400
Co-insurance	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.