SUMMARY OF MEDICAL BENEFITS FOR OFFICIAL GVSU RETIREES

For faculty and staff members hired prior to January 1, 2014

2024

GRAND VALLEY STATE UNIVERSITY
HUMAN RESOURCES

This document contains the best information available at the time it was written. If any information in it differs from that found in the summary plan descriptions and/or other legal documents describing the particular topics in this material, the legal descriptions or other documents will prevail. These documents are available at www.gvsu.edu/hro/benefits or by contacting the Human Resources Office at (616) 331-2215.

The university retains the right to modify or terminate this plan upon reasonable notice to faculty, staff and retirees.

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WHAT IS AN OFFICIAL RETIREE?

An Official Retiree is a benefit eligible faculty/staff member who was hired prior to January 1, 2014 and whose years of service at GVSU plus their age total a minimum of 75 at the time of retirement. Affiliate Faculty are not eligible for the medical related benefits. Visiting Faculty and Adjunct AP Staff are not eligible for Official Retiree status.

MEDICAL COVERAGE

Official Retirees of GVSU may purchase medical coverage in the GVSU Retiree Medical Plan until they turn 65. The amount paid towards a retiree's medical coverage is based on years of service, with 25 years needed to be eligible for the maximum (a list of rates is available on page 6). See the Health Insurance Marketplace Notice at the end of this document for more details about this plan and the Affordable Care Act.

After age 65, the University recommends that official retirees secure a Medicare Supplement policy that meets their needs. The retiree makes premium payments to the insurance company and the University reimburses the retiree for a portion of the cost of their Medicare Supplement policy based on years of service (see the reimbursement schedule on page 7). The retiree must also purchase Medicare Part B.

Spouses of official retirees are also eligible for reimbursements. The spouse monthly reimbursement is $25 less than the amount reimbursed for the retiree.

PRESCRIPTION COVERAGE

Prescription drug coverage is not included in the GVSU retiree medical plan or most Medicare supplements. Regardless of age, all official retirees of GVSU have the opportunity to participate in a prescription discount program. This discount program is coordinated with GVSU's current group prescription provider. Information on this program is available on the Retiree Benefits page on our website. Retirees over the age of 65 should investigate Medicare Part D prescription drug coverage.

DENTAL INSURANCE

Dental coverage ends on your retirement date. Approximately 10 to 15 business days after your retirement date you will receive COBRA continuation coverage information from iSolved Benefits Services, our COBRA administrator. You can continue COBRA dental coverage for up to 18 months by paying the appropriate COBRA premium. (See page 8)

VISION INSURANCE

Retirees that will be enrolling in the GVSU Retiree Medical Plan will automatically be enrolled in the PriorityVision plan. The benefit entitles you to a free routine eye exam and Glaucoma test once every two years. A network provider must be used.

If you had VSP Vision coverage at the time of your retirement, you will have the option of continuing coverage for up to 18 months by paying the appropriate COBRA premium. (See page 8)

HEALTH SAVINGS ACCOUNT

Your Health Savings Account is your personal bank account. When leaving GVSU, you take the money with you, and use the money tax-free for medical expenses. When you enroll in Medicare, you can use your account to pay Medicare premiums, deductibles, copays, and coinsurance under any part of Medicare. You cannot use your account for is to purchase a Medicare supplemental insurance or "Medigap" policy.

Because the GVSU Retiree Medical Plan and Medicare are not High Deductible Health Plans you will not be able to make contributions to your HSA.

For specific questions regarding your HSA, please contact HealthEquity.

FLEXIBLE SPENDING ACCOUNT

Coverage under the Health Care and Dependent Care Flexible Spending Accounts will end on your retirement date.

Participants in the Health FSA may submit claims for reimbursement for Eligible Medical Expenses arising during the plan year and before the retirement date. The claims must be made within 90 days of the retirement date. Unless a COBRA election is made to continue your FSA participants are not entitled to receive reimbursement for expenses incurred after the last day of employment. If you do choose to continue coverage through COBRA the contributions to your FSA will be after-tax dollars. You should seek professional tax assistance on the tax status of these contributions.

Participants in the Dependent Care FSA may continue to submit claims for eligible dependent care expenses incurred through the remainder of the plan year in which they retire as long as there are still funds remaining in the account

LIFE INSURANCE

Life insurance coverage ends at retirement. A retiree may convert the GVSU term life insurance to whole life insurance by paying the appropriate conversion premium.

MGS & PSS RETIREMENT PLAN A (PENSION)

Maintenance, Grounds, and Service Staff (MGS) members hired prior to 10/08/2004 are participants in the MGS Retirement Plan A. Professional Support Staff (PSS) members hired prior to 02/02/2006 and Police staff members hired prior to 03/04/2007 are participants in the PSS Retirement Plan A. If you are a participant, please contact the Human Resources Office.

OTHER BENEFITS

Official retirees, regardless of their date of hire, are eligible to use the Faculty/Staff Assistance Plan through Encompass. They may also use the Recreation Center, participate in Recreation & Wellness Programs and use both libraries. They enjoy free campus parking (contact the President's Office or Human Resources for a permit), may maintain e-mail access, receive GVSU publications, and are invited to University events. In addition, official retirees remain eligible for the Academic Participation program and have access to GVSU Relocation Resources and eLearning Technologies courses.

GIVING TO GRAND VALLEY

You have made an impression on students, your colleagues, your department, and Grand Valley overall. Thank you for your dedication and commitment to making GVSU a better place. As you consider retirement and how to continue making an impact on students, an option would be to leave Grand Valley in your estate plans. There are several opportunities for continued support and involvement, such as giving toward a scholarship, supporting a program you care about, or addressing another need you have identified on campus. Including Grand Valley in your estate plans can be simple, meaningful for you and the campus community, and potentially tax beneficial for your loved ones. Please contact Andrew Bixel, Director of Endowed and Planned Giving, at bixela@gvsu.edu or (616) 331-5619 to learn how you can help Grand Valley students, faculty and staff, and our community.

GVSU RETIREES MEDICAL PROGRAM

For Retirees Under the Age of 65

Official retirees under the age of 65 may enroll in the GVSU Retiree Medical Plan and will be covered on the plan until their 65th birthday. Spouses of official retirees are also eligible for this program. Premium amounts are based on the official retiree's years of service at GVSU. After completing and submitting an enrollment form the retiree is billed monthly for this coverage.

If the retiree obtains other employment after leaving GVSU and is covered by their new employer's medical plan the new employer's medical plan will be primary for the payment of medical claims. The GVSU Retirees' Medical Program will be the secondary payer.

GVSU will pay up to $150/month for the retiree's coverage and up to $125/month for the retiree's spouse's coverage. Prescription drugs are not a covered benefit in this medical plan. However, a separate prescription discount program is available.

Years of Service at GVSU	% of GVSU Contribution Cap	GVSU Monthly Contribution	2024 Retiree's Monthly Premium	2024 Retiree's Spouse's Premium
25	100%	$150.00	$391.00	$416.00
24	95%	$142.50	$398.50	$423.50
23	90%	$135.00	$406.00	$431.00
22	85%	$127.50	$413.50	$438.50
21	80%	$120.00	$421.00	$446.00
20	75%	$112.50	$428.50	$453.50
19	70%	$105.00	$436.00	$461.00
18	65%	$97.50	$443.50	$468.50
17	60%	$90.00	$451.00	$476.00
16	55%	$82.50	$458.50	$483.50
15	50%	$75.00	$466.00	$491.00
14	45%	$67.50	$473.50	$498.50
13	40%	$60.00	$481.00	$506.00
12	35%	$52.50	$488.50	$513.50
11	30%	$45.00	$496.00	$521.00
10	25%	$37.50	$503.50	$528.50
<10	20%	$30.00	$511.00	$536.00

The university retains the right to modify or terminate this plan upon reasonable notice to faculty, staff and retirees.

For Retirees Over the Age of 65

Official retirees over the age of 65 may purchase Medigap coverage or a Medicare Advantage plan from the insurance vendor of their choice. GVSU will help to pay for this coverage prospectively. Checks are issued in January for the period of January 1 through June 30 and in July for the period of July 1 through December 31. The spouse of an official retiree is eligible for an amount based on their age, less $25.

Reimbursement amounts are based on the official retiree's years of service at GVSU.

Proof of purchase is required in order to receive reimbursement. A copy of a receipt, canceled check or statement showing a direct deposit are all acceptable forms of proof. The proof of purchase should be sent to Human Resources annually in December. The amount of the reimbursement will be the actual cost of the policy or the amount shown in the reimbursement schedule below, whichever is less.

Years of Service at GVSU	% of GVSU Contribution Cap	GVSU Monthly Contribution for Retirees age 65-69	GVSU Monthly Contribution for Retirees age 70-75	GVSU Monthly Contribution for Retirees age 76+
25	100%	$70.00	$80.00	$90.00
24	95%	$66.50	$76.00	$85.50
23	90%	$63.00	$72.00	$81.00
22	85%	$59.50	$68.00	$76.50
21	80%	$56.00	$64.00	$72.00
20	75%	$52.50	$60.00	$67.50
19	70%	$49.00	$56.00	$63.00
18	65%	$45.50	$52.00	$58.50
17	60%	$42.00	$48.00	$54.00
16	55%	$38.50	$44.00	$49.50
15	50%	$35.00	$40.00	$45.00
14	45%	$31.50	$36.00	$40.50
13	40%	$28.00	$32.00	$36.00
12	35%	$24.50	$28.00	$31.50
11	30%	$21.00	$24.00	$27.00
10	25%	$17.50	$20.00	$22.50
<10	20%	$14.00	$16.00	$18.00

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COBRA Medical Coverage

- You will receive information from our COBRA administrator, iSolved Benefits Services, approximately 15 business days following your retirement date.
- COBRA coverage is the same group coverage you had while employed.
- Coverage can be elected for yourself and any dependents that were covered on your GVSU plan.
- You have 60 days from the date on the COBRA notice that you receive from iSolved to make your elections.
- If COBRA is elected, the coverage will be retroactive back to the date you lost coverage.
- You are responsible for paying the COBRA premiums directly to iSolved.
- Generally, you can be enrolled in COBRA for up to 18 months or until entitled to Medicare, whichever is less.

2024 COBRA MONTHLY PREMIUM RATES, EFFECTIVE 1/1/2024

GVSU Standard PPO	**COBRA**
Single	$680.39
Dual	$1,319.95
Family	$2,041.17
GVSU HDHP PPO with HSA	
Single	$564.33
Dual	$1,094.79
Family	$1,692.98
EyeMed	
Single	$7.10
Dual	$14.20
Family	$21.29
Delta Dental	
Single	$36.37
Dual	$68.63
Family	$128.35

SOCIAL SECURITY

This fact sheet provides a snapshot of the most important features of the Social Security, Supplemental Security Income (SSI) and Medicare Programs. If you need specific information about any one of these programs, call the toll-free number, 1-800-772-1213, to ask for Social Security publications or to speak to a Social Security representative. You may also access the Social Security Administration on online at www.ssa.gov.

The Social Security Number

The benefits you'll receive from Social Security will be calculated on the earnings and other information recorded under your Social Security number. So it's important that you always use the proper number. Also, you should make sure the name you use at work is the same as the name shown on your Social Security card. If you ever change your name, you should change the name on your Social Security Card, too. Social Security does not charge for this service.

Paying Social Security Taxes

While you work at GVSU, we withhold Social Security and Medicare taxes from your paycheck, match that amount, send those taxes to the Internal Revenue Service (IRS) and report your earnings to Social Security.

Earning Social Security "Credits"

As you work and pay taxes, you earn credits that count toward eligibility for future Social Security benefits. You can earn a maximum of four credits each year. Most people need 40 credits (10 years of work) to qualify for benefits. Fewer credits are needed to qualify for disability or survivors benefits.

Social Security Benefits

Your Social Security benefit is a percentage of your earnings averaged over most of your working lifetime. Social Security was never intended to be your only source of income when you retire or become disabled or your family's only income if you die or are disabled. It is intended to supplement other income you may have through pension plans, savings, investments, etc. The Social Security office provides all eligible participants with an estimated benefit on an annual basis.

There are five major categories of benefits paid for through your Social Security taxes: retirement, disability, family benefits, survivors and Medicare. (SSI benefits, which are not financed by Social Security taxes are discussed in another section.)

RETIREMENT

Full retirement age (also called "normal retirement age") had been 65 for many years. However, beginning with people born in 1938 or later, that age gradually increases until it reaches 67 for people born after 1959. People who delay retirement beyond age 65 receive a special increase in their benefits when they do retire.

DISABILITY

Benefits are payable at any age to people who have enough Social Security credits and who have a severe physical or mental impairment that is expected to prevent them from doing "substantial" work for a year or more or who have a condition that is expected to result in death. Generally, earnings of $500 or more per month are considered substantial. The disability program includes incentives to smooth the transition back into the workforce, including continuation of benefits and health care coverage while a person attempts to work.

FAMILY BENEFITS

If you are eligible for retirement or disability benefits, other members of your family might receive benefits, too. These include: your spouse if he or she is at least 62 years old or under 62 but caring for a child under age 16; and your children if they are unmarried and under age 18, under 19 but still in school or 18 or older but disabled. If you are divorced, your ex-spouse could be eligible for benefits on your record.

SURVIVORS

When you die, certain members of your family may be eligible for benefits if you earned enough Social Security credits while you were working. The family members include: a widow(er) age 60 or older, 50 or older if disabled or any age if caring for a child under age 16; your children if they are unmarried and under age 18, under 19 but still in school or 18 or older but disabled; and your parents if you were their primary means of support. A special one-time payment of $255 may be made to your spouse or minor children when you die. If you are divorced, your ex-spouse could be eligible for a widow(er)'s benefit on your record.

SUPPLEMENTAL SECURITY INCOME BENEFITS

SSI makes monthly payments to people who have a low income and few assets. To get SSI, you must be 65 or older or be disabled. Children as well as adults qualify for SSI disability payments. As its name implies, Supplemental Security Income "supplements" your income up to various levels–depending on where you live.

The federal government pays a basic rate and some states add money to that amount. Check with your local Social Security office for the SSI rates in your state. Generally, people who get SSI also qualify for Medicaid, food stamps and other assistance.

SSI benefits are not paid from Social Security trust funds and are not based on past earnings. Instead, SSI benefits are financed by general tax revenues and assure a minimum monthly income for elderly and disabled persons.

WHEN AND HOW TO FILE FOR SOCIAL SECURITY OR SSI

You should file for Social Security or SSI disability benefits when you become too disabled to work and for survivors benefits when a family breadwinner dies. When you're thinking about retirement, you should talk to a Social Security representative 12 to 18 months before you plan to retire. It may be to your advantage to start your retirement benefits before you actually stop working.

To file for benefits, get information or speak to a Social Security representative, call the toll-free number: 800-772-1213. You also can use that number to set up an appointment to visit your local Social Security office. The lines are busiest early in the week and early in the month, so, if your business can wait, it's best to call at other times.

When you file for benefits, you need to submit documents that show you're eligible, such as a birth certificate for each family member applying for benefits, a marriage certificate if your spouse is applying and your most recent W-2 form.

The Social Security Administration treats all calls confidentially whether they're made to the toll-free numbers, or to one of the local offices.

MEDICARE

The following provides basic information about what Medicare is, who is covered and some of the options you have for choosing Medicare coverage. For the latest information about Medicare, visit the website or call the toll-free number listed below:

- Website: www.medicare.gov
- Toll-free number: 1-800-MEDICARE (1-800-633-4227)
- TTY number: 1-877-486-2048

Medicare is our country's health insurance program for people age 65 or older. Certain people younger than age 65 can qualify for Medicare, too, including those who have disabilities and those who have permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's disease). The program helps with the cost of health care, but it does not cover all medical expenses or the cost of most long-term care.

Medicare is financed by a portion of the payroll taxes paid by workers and their employers. It also is financed in part by monthly premiums deducted from Social Security checks.

The Centers for Medicare & Medicaid Services is the agency in charge of the Medicare program. But you apply for Medicare at Social Security, and we can give you general information about the Medicare program.

Medicare has four parts:

1. Hosptial insurance (Part A) that helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some health care and hospice care.
2. Medical Insurance (Part B) that helps pay for doctors' services and many other medical services and supplies that are not covered by hospital insurance.
3. Medicare Advantage (Part C) plans are available in many areas. People with Medicare Parts A and B can choose to receive all of their health care services through one of these provider organizations under Part C.
4. Presription drug coverage (Part D) that helps pay for medications doctors prescribe for treatment.

You can get more detailed information about what Medicare covers from Medicare & You (Publication No. CMS-10050). To get a copy, call the Medicare toll-free number, 1-800-MEDICARE (1-800-633-4227), or go to www.medicare.gov. If you are deaf or hard of hearing, you may call TTY 1-877-486-2048.

Hospital Insurance (Part A)

Most people age 65 or older who are citizens or permanent residents of the United States are eligible for free Medicare hospital insurance (Part A). You are eligible at age 65 if:

- You receive or are eligible to receive Social Security benefits; or
- You receive or are eligible to receive railroad retirement benefits; or
- You or your spouse (living or deceased, including divorced spouses) worked long enough in a government job where Medicare taxes were paid; or
- You are the dependent parent of someone who worked long enough in a government job where Medicare taxes were paid.

If you do not meet these requirements, you may be able to get Medicare hospital insurance by paying a monthly premium. Usually, you can sign up for this hospital insurance only during designated enrollment periods.

Before age 65, you are eligible for free Medicare hospital insurance if:

- You have been entitled to Social Security disability benefits for 24 months; or
- You receive a disability pension from the railroad retirement board and meet certain conditions; or
- You have Lou Gehrig's disease (amyotrophic lateral sclerosis); or
- You worked long enough in a government job where Medicare taxes were paid and you meet the requirements of the Social Security disability program; or
- You are the child or widow(er) age 50 or older, including a divorced widow(er) of someone who has worked long enough in a government job where Medicare taxes were paid and you meet the requirements of the Social Security disability program.
- You have permanent kidney failure and you receive maintenance dialysis or a kidney transplant and:
    - You are eligible for or receive monthly benefits under Social Security or the railroad
    - retirement system; or
    - You have worked long enough in a Medicare-covered government job; or
    - You are the child or spouse (including a divorced spouse) of a worker (living or deceased) who has worked long enough under Social Security or in a Medicare-covered government job.

Medical Insurance (Part B)

Anyone who is eligible for free Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium. Some beneficiaries with higher incomes will pay a higher monthly Part B premium. For more information, ask for Medicare Part B Premiums: New Rules For Beneficiaries With Higher Incomes (Publication No. 05-10536) or visit www.ssa.gov/pubs/10536.pdf.

If you are not eligible for free hospital insurance, you can buy medical insurance, without having to buy hospital insurance, if you are age 65 or older and you are:

- A U.S. citizen; or
- A lawfully admitted non-citizen that has lived in the U.S. for at least five years.

Medical Advantage Plans (Part C)

If you have Medicare Parts A and B, you can join a Medicare Advantage plan. With one of these plans, you do not need a Medigap policy, because Medicare Advantage plans generally cover many of the same benefits that a Medigap policy would cover, such as extra days in the hospital after you have used the number of days that Medicare covers.

Medicare Advantage plans include:

- Medicare managed care plans;
- Medicare preferred provider organization (PPO) plans;
- Medicare private fee-for-service plans; and
- Medicare specialty plans.

If you decide to join a Medicare Advantage plan, you use the health card that you get from your Medicare Advantage plan provider for your health care. Also, you might have to pay a monthly premium for your Medicare Advantage plan because of the extra benefits it offers.

Medical Prescription Drug Plans (Part D)

Anyone who has Medicare hospital insurance (Part A), medical insurance (Part B) or a Medicare Advantage plan (Part C) is eligible for prescription drug coverage (Part D). Joining a Medicare prescription drug plan is voluntary, and you pay an additional monthly premium for the coverage. You can wait to enroll in a Medicare Part D plan if you have other prescription drug coverage but, if you don't have prescription coverage that is, on average, at least as good as Medicare prescription drug coverage, you will pay a penalty if you wait to join later. You will have to pay this penalty for as long as you have Medicare prescription drug coverage.

When Should I Apply?

If you are already getting Social Security retirement or disability benefits or railroad retirement checks, you will be contacted a few months before you become eligible for Medicare and given the information you need. You will be enrolled in Medicare Parts A and B automatically. However, because you must pay a premium for Part B coverage, you have the option of turning it down.

If you are not already getting retirement benefits, you should contact us about three months before your 65th birthday to sign up for Medicare. You can sign up for Medicare even if you do not plan to retire at age 65. If you are covered under an employer group health plan, you do not have to enroll in Medicare when you turn 65.

Once you are enrolled in Medicare, you will receive a red, white and blue Medicare card showing whether you have Part A, Part B or both. Keep your card in a safe place so you will have it when you need it. If your card is ever lost or stolen, you can apply for a replacement card or call Social Security's toll-free number. You will also receive a Medicare & You (Publication No. CMS-10050) handbook that describes your Medicare benefits and Medicare plan choices.

Special Enrollment Situations

You should also contact Social Security about applying for Medicare if:

- You are a disabled widow or widower between age 50 and age 65, but have not applied for disability benefits because you are already getting another kind of Social Security benefit;
- You are a government employee and became disabled before age 65;
- You, your spouse or your dependent child has permanent kidney failure;
- You had Medicare medical insurance in the past but dropped the coverage; or
- You turned down Medicare medical insurance when you became entitled to hospital insurance (Part A).

Initial Enrollment Period for Part B

When you first become eligible for hospital insurance (Part A), you have a seven-month period (your initial enrollment period) in which to sign up for medical insurance (Part B). A delay on your part will cause a delay in coverage and result in higher premiums.

If you are eligible at age 65, your initial enrollment period begins three months before your 65th birthday, includes the month you turn age 65 and ends three months after that birthday. If you are eligible for Medicare based on disability or permanent kidney failure, your initial enrollment period depends on the date your disability or treatment began.

When Does My Enrollment in Part B Become Effective?

If you accept the automatic enrollment in Medicare Part B, or if you enroll in Medicare Part B during the first three months of your initial enrollment period, your medical insurance protection will start with the month you are first eligible. If you enroll during the last four months, your protection will start from one to three months after you enroll.

General Enrollment Period for Part B

If you do not enroll in Medicare Part B during your initial enrollment period, you have another chance each year to sign up during a "general enrollment period" from January 1 through March 31. Your coverage begins the following July. However, your monthly premium increases 10 percent for each 12-month period you were eligible for, but did not enroll in, Medicare Part B.

Special Enrollment Period for People Covered Under an Employer Group Health Plan

If you are 65 or older and are covered under a group health plan, either from your own or your spouse's current employment, you have a "special enrollment period" in which to sign up for Medicare Part B. This means that you may delay enrolling in Medicare Part B without having to wait for a general enrollment period and paying the 10 percent premium surcharge for late enrollment. The rules allow you to:

- Enroll in Medicare Part B any time while you are covered under the group health plan based on current employment; or
- Enroll in Medicare Part B during the eight-month period that begins with the month your group health coverage ends, or the month employment ends—whichever comes first.

Special enrollment period rules do not apply if employment or employer-provided group health plan coverage ends during your initial enrollment period.

If you do not enroll by the end of the eight-month period, you will have to wait until the next general enrollment period, which begins January 1 of the next year. You also may have to pay a higher premium, as described in General enrollment period for Part B.

People who receive Social Security disability benefits and are covered under a group health plan from either their own or a family member's current employment also have a special enrollment period and premium rights that are similar to those for workers age 65 or older.

WHAT MEDICARE DOES NOT COVER

There are many health care services that Medicare Parts A and B do not cover, including:

- Items or services not considered medically reasonable and necessary;
- Long-term nursing home stays;
- Custodial care in a nursing home;
- Private duty nurses at home;
- Homemaker services;
- Routine dental services and dentures;
- Routine physicals;
- Preventive care;
- Vision exams and eye glasses;
- Hearing tests and hearing aids;
- Routine foot care;
- Physician's charges above Medicare's approved amount;
- Care received outside of the US

PRIVATE SUPPLEMENTAL INSURANCE ("MEDIGAP")

Purchasing a good Medicare supplemental insurance policy is one way to fill the gaps in Medicare coverage and limit what you pay out of your own pocket for health care services. Private supplemental insurance policies usually fill the gaps in Medicare coverage (primarily deductibles and coinsurance).

Before purchasing a supplemental insurance policy, check with your State Insurance Commission for information to help you compare the various supplemental policies sold in your state. In Michigan, the Michigan Medicare/Medicaid Assistance Program (MMAP) will furnish a copy of the most recent Medigap policy comparison if you call them at (800) 803-7174.

RETIREMENT CONTACTS & RESOURCES

Name	Role	Contact	Group/Plan #
GVSU Human Resources	General inquiries	(616) 331-2215	
	HR Business Partners	www.gvsu.edu/hro/hrbp	
Encompass	Employee Assistance Program	(800) 788-8630	
		www.mylifeexpert.com	
AARP	General inquiries	(888) 687-2277	
		www.aarp.org	
Alzheimer's Association	Alzheimer's inquiries	(800) 272-3900	
		www.alz.org	
Area Agency on Aging of West Michigan	General inquiries	(800) 442-2803	
		www.areaagencyonaging.com	
Citizens for Better Care	General inquiries	(866) 485-9393	
		www.cbcmi.org	
CVS Caremark	Prescription coverage	(888) 549-5789	GVSUN
		www.caremark.com	
Delta Dental	Dental Coverage	(800) 524-0149	7410-0001
		www.deltadentalmi.com	
Department of Health and Human Serives	General inquiries	(877) 696-6775	
		www.hhs.gov	

RETIREMENT CONTACTS & RESOURCES CONT.

Name	Role	Contact	Group/Plan #
Disability Network of Michigan	Disability inquiries	(517) 339-0539	
		www.dnmichigan.org	
VSP Vision	Vision coverage	(800) 877-7195	30100707
		www.vsp.com	
Fidelity Investments	Retirement accounts	(800) 343-3548	50094 (403b), 72992 (457b)
		www.fidelity.com	
Genworth Financial	Long-term care insurance	(877) 724-6699	GVSU
		www.genworth.com/groupltc	
Health Insurance Marketplace	Medical coverage	(800) 318-2596	
		www.healthcare.gov	
iSolved Benefit Services	COBRA coverage	(800) 594-6957	
		www.isolved.com	
	Flexible Spending Accounts (FSA)	(866) 370-3040	
		www.isolved.com	
Lincoln Financial Group	Life insurance	(800) 423-2765	GRANDVALLE
		www.lfg.com	
Priority Health	Medical coverage	(800) 956-1954	733710
		www.priorityhealth.com	
Priority Vision	Vision coverage	(877) 572-4001	9245663
		www.eyemedvisioncare.com/prihealth	
TIAA	Retirement accounts	(800) 842-2776	
		www.tiaa.org	
HealthEquity	Health Savings Accounts (HSA)	(866) 346-5800	
		www.healthequity.com	
United Way 2-1-1 (formerly First Call For Help)	General inquiries	2-1-1	
		www.211.org	

MEDICAL SUPPLEMENTAL/MEDICARE ADVANTAGE INSURANCE CONTACT SHEET

General Information

- Centers for Medicare and Medicaid Services : www.cms.gov
- Medicare: www.medicare.gov
- Medicare and You: www.q1medicare.com/pics/ContentPics/MedicareAndYou2012_10050.pdf
- Michigan Medicare/Medicaid Assistance Program (MMAP): www.mmapinc.org; 1-800-803-7174
- AARP: www.aarp.org/health/medicare-insurance

Where to Purchase

- Your personal financial advisor
- Your personal home and auto insurance agent

LOCAL AGENT/BROKERS

- Schullo & Associates, Patrick J. Schullo: (800) 367-8933
- Houlmont and Associates: (800) 530-9233; www.houlmont.com
- Weadock & Associates: (616) 464-0760
- Dave Zylstra Agency, Inc.: (616) 791-4200

LOCAL MEDICARE ADVANTAGE PROVIDERS

- Blue Cross Blue Schield of Michigan Medicare: (877) 459-2583; www.bcbsm.com/medicare
- Priority Health Medicare: (888) 389-6676; www.priorityhealth.com/medicare

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution–as well as your employee contribution to employer-offered coverage–is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an aftertax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact GVSU Human Resources at (616) 331-2215.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

GRAND VALLEY STATE UNIVERSITY
SCHEDULE OF MEDICAL BENEFITS
Preferred Provider Organization (PPO) Plan – Retiree Plan
Effective Date: January 1, 2024
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 priorityhealth.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. Your provider must access the Priority Health provider portal to prior certify services. If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, your provider must notify the Behavioral Health Department as soon as possible at **(616) 464-8500** or **(800) 673-8043** for assistance. You do not need prior certification 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.)	$9,450 per individual; $18,900 per family per plan year.	$9,450 per individual; $18,900 per family per plan 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 in the member center the website at 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 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 priorityhealth.com and choose "PriorityVision", or call the Priority Health Customer Service Department at **877 572-4001**.		
Virtual Care Services		
Virtual Care Services Limited-service virtual care only.	$20 copayment per visit. Deductible does not apply.	Covered at 70% after deductible.
Medical Office/Home 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.
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.	Covered at 70% after deductible.
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/Home 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 certification 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.	Covered at 90% after deductible.	Covered at 70% after deductible.
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 lifetime 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.	Covered at 70% after deductible.

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 certification required.	Covered at 90% after deductible.	Covered at 70% after deductible.
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 the 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 subacute residential treatment facility and partial hospitalization.) Prior certification required except in emergencies.	Covered at 90% after deductible.	Covered at 70% after deductible.
Outpatient Office Services for Mental Health & Substance Use Disorder 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.
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 at 100% when performed in physician's office. Deductible does not apply. Covered at 90% after deductible when performed in an inpatient or outpatient facility.	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 certification 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		
Physical, Occupational and Speech Therapy; Applied Behavior 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 certification required for ABA.	Covered at 70% after deductible up to a benefit maximum of 135 days per plan year. Prior certification 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.	Covered at 70% after deductible.

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.
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.

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.

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.)


Grand Valley
State University
Human Resources