GRAND VALLEY STATE UNIVERSITY
SCHEDULE OF MEDICAL BENEFITS
PREFERRED PROVIDER ORGANIZATION (PPO) PLAN
HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
Effective Date: January 1, 2025
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 our Behavioral Health Department as soon as possible at **(616) 464-8500** or **(800) 673-8043** for assistance. You do not need prior certification from Priority Health for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Other services requiring prior certification are:

- Home Health Care
- Skilled Nursing, Sub acute & Long-term Acute Facility Care
- Inpatient Rehabilitation Care
- Durable Medical Equipment over $1,000
- 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.

Deductibles:

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

- Network preventive health services that are listed in Priority Health's preventive health care guidelines.
- Network routine maternity services provided in your physician's office (deductible **will** apply to delivery, facility charges and anesthesia charges associated with the delivery).

If you have individual coverage, you must meet the individual deductible below. If you have more than one person in your family, you have family coverage, and the family deductible below must be met. The family deductible can be satisfied by only one family member or by any combination of family members.

Network deductible amounts apply to non-network deductible amounts, and non-network deductible amounts apply to network deductible amounts.

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

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

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

Out-of-Pocket Limits:

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

Network out-of-pocket limit amounts apply to non-network out-of-pocket limit amounts; and non-network out-of-pocket limit amounts apply to network out-of-pocket limit amounts.

If you have individual coverage, you must meet the individual out-of-pocket limit below. If you have more than one person in your family, you have family coverage and the family out-of-pocket limit below must be met. The family out-of-pocket limit can be satisfied by only one family member or by any combination of family members.

Notwithstanding the above, the following out-of-pocket costs do not apply towards the out-of-pocket limit: Expenses for non-covered services, services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); and costs paid by participants to provider for non-network benefits that exceed reasonable and customary.

The following information is provided as a summary of benefits available under your plan. This summary is not intended as a substitute for your 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 BENEFIT	NON-NETWORK BENEFIT
Deductibles	$2,250 per individual; $4,500 per family per plan year.	$4,500 per individual; $9,000 per family per plan year.
Benefit Percentage Rate	100% paid by the plan; 0% paid by the participant, unless otherwise noted.	80% paid by the plan; 20% paid by the participant, unless otherwise noted.
Out-of-Pocket Limits (Annual out-of-pocket costs for health care, including deductibles, coinsurance and copayments, including prescription drug copayment cap, are limited under the ACA.)	$2,500 per individual; $5,000 per family per plan year.	$6,500 per individual; $13,000 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 at 100%. Deductible does not apply.	Covered at 80% after deductible.
Women's Preventive Health Care Services	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Routine Laboratory Tests, Screening and Counseling	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
PSA Tests, Prostate Exams and Colon/Rectal Screenings	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Immunizations	Covered at 100%. Deductible does not apply.	Covered at 80% 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 80% 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.	Covered at 100% after deductible.	Covered at 80% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
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.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Retail Health Clinic Visits (Located within the United States.)	Covered at 100% after deductible.	Covered at 100% after deductible for visits at reasonable and customary for evaluation and management services only.
Office Surgery (Performed in physician's office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Office Injections (Performed in physician's office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Allergy Office Services (Including allergy testing and injections, including serum costs.) (Performed in physician's office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician's office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Advanced Diagnostic Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies Prior certification required. (Performed in physician's office.)	Covered at 100% after deductible.	Covered at 80% 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 80% after deductible.
Maternity Education Classes	Attendance at an approved maternity education program is covered at 100% after deductible.	Not covered.
Education Services (Other than as provided in Priority Health's Preventive Health Care Guidelines.)	Covered at 100% after deductible.	Covered at 80% 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 100% after deductible.	Covered at 80% 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 100% after deductible.	Covered at 80% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Hospital Services (continued)		
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 100% 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 100% 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 100% after deductible.	Covered at 80% after deductible.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center or freestanding facility charges.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 100% after deductible.	Covered at 80% after deductible.
Obstetrical Services in Hospital (Includes delivery, facility and anesthesia services.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Hospital and Freestanding Facility Diagnostic Laboratory & Radiology Services	Covered at 100% after deductible.	Covered at 80% 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 100% after deductible.	Covered at 80% after deductible.
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 100% 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 80% 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 100% after deductible.	Covered at 80% 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.		

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered at 100% after deductible.	Paid at the Network benefit level. Reasonable and customary limitations apply.
Ambulance Services	Covered at 100% after deductible.	Paid at the Network benefit level. Reasonable and customary limitations apply.
Urgent Care Facility Services	Covered at 100% after deductible.	Covered at 80% 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 100% after deductible.	Covered at 80% after deductible.
Outpatient Mental Health & Substance Use Disorder Services Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Family Planning and Reproductive Services		
Infertility Counseling & Treatment Covered for diagnosis and treatment of underlying cause only. Limitations and exclusions apply.	Covered at 100% after deductible.	Covered at 80% after deductible.
Vasectomy	Covered at 100% after deductible.	Covered at 80% after deductible.
Tubal Ligation/Tubal Obstructive Procedures (Included as part of the Women's Preventive Health Services benefits.)	Covered at 100%, deductible waived when performed at outpatient facilities. 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 80% after deductible.
Birth Control Services Medical Plan (i.e. doctor's office) (Included as part of the Women's Preventive Health Services benefits.) Includes; diaphragms, implantables, injectables, and IUD (insertion and removal), etc.	Covered at 100%, deductible waived.	Covered at 80% after deductible.
Gender Dysphoria or Reassignment Services Prior certification required.	Covered at 100% after deductible.	Covered at 80% 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 100% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 80% after deductible up to a benefit maximum of 30 visits per plan year. *
Speech Therapy (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 80% 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 100% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 80% 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.		

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Habilitative Services Related to the Treatment of Autism Spectrum Disorder		
Physical, Occupational and Speech Therapy; Applied Behavior Analysis (ABA) for Autism Treatment Prior certification required for ABA.	Covered at 100% after deductible.	Covered at 80% after deductible.
Other Services		
Prescription Drugs – Administered by CVS Caremark Includes coverage for specified drugs and medications required by PPACA. More information about prescription drug coverage is available at www.caremark.com or by calling **(888) 549-5789**.	Covered prescription drugs apply to the plan deductible and out-of-pocket maximum. Copayments apply after satisfaction of the deductible and have an annual limit of $250 single and $500 dual/family. Retail Pharmacy (up to 31 days): Generic Drugs: $4 copayment Preferred Brand Name Drugs: $20 copayment Non-Preferred Brand Name Drugs: $40 copayment Mail Service Program (up to 90 days): Generic Drugs: $8 copayment Preferred Brand Name Drugs: $40 copayment Non-Preferred Brand Name Drugs: $80 copayment Retail 90 Program (up to 90 days): Generic Drugs: $12 copayment Preferred Brand Name Drugs: $60 copayment Non-Preferred Brand Name Drugs: $120 copayment Check with Caremark RX plan for specialty drug benefits.	
Durable Medical Equipment Prior certification is required for charges over $1,000. • Surgical bras after mastectomy: Limited to 4 bras per plan year. • Compression Stockings: Limited to 12 pairs per plan year.	Covered at 100% after deductible.	Covered at 80% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over $1,000.	Covered at 100% after deductible.	Covered at 80% after deductible.
Wigs, Toupees and Hairpieces Covered when prescribed by a physician for a medical condition.	Covered at 100% after deductible.	Covered at 80% after deductible.
Chiropractic Services and Osteopathic Manipulation Therapy Visits (Combined Network/Non-Network Benefit.) (Including maintenance care and massage therapy.)	Covered at 100% after deductible up to a benefit maximum of 30 visits per plan year.	Covered at 80% 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 100% after deductible.	Covered at 80% after deductible.
Orthognathic Surgery & Treatment	Not covered.	Not covered.
Cochlear Implants	Not covered.	Not covered.
Non-Hospital Facility Services – Including skilled nursing care services received in a: • Skilled Nursing Care Facility • Subacute Facility • Inpatient Rehabilitation Facility • Hospice Facility Prior certification required, except for hospice facilities.	Covered at 100% after deductible up to a maximum of 120 days per plan year.	Covered at 80% after deductible up to a maximum of 120 days per plan year.
Home Health Services (Combined Network/Non-Network Benefit.) Prior certification required.	Covered at 100% after deductible up to a maximum of 60 visits per plan year.	Covered at 80% after deductible up to a maximum of 60 visits per plan year.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (continued)		
Hospice Services (Includes hospice, bereavement and respite services.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Hemodialysis, Radiation Therapy and Chemotherapy	Covered at 100% after deductible.	Covered at 80% after deductible.
Private Duty Nursing (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 60 visits per plan year	Covered at 80% after deductible up to a benefit maximum of 60 visits per plan year.
Hearing Services (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible. Hearing aids are limited to a $750 maximum benefit per ear every 36 months.	Covered at 80% after deductible. Hearing aids are limited to a $750 maximum benefit per ear every 36 months.
Eye Care Services Covered for treatment of medical conditions and diseases of the eye only.	Covered at 100% after deductible.	Covered at 80% after deductible.
Coverage Information		
Waiting Period Requirement	Benefits become effective upon the date of hire.	
Full-Time Employee	30 hours worked per week.	
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.

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.)