

GVSU Health Care Plans

Effective January 1, 2010

	GVSU Base PPO Participates with Cofinity (PPOM) Network (Beech Street - out of network travel only) Administered by UMR				GVSU Enhanced PPO Participates with Cofinity (PPOM) Network (Beech Street - out of network travel only) Administered by UMR				Priority Health HMO				Grand Valley Health Plan HMO			
Faculty / Staff Premiums		Annual	Staff 24 Per Pay Amounts	Faculty 18 Per Pay Amounts		Annual	Staff 24 Per Pay Amounts	Faculty 18 Per Pay Amounts		Annual	Staff 24 Per Pay Amounts	Faculty 18 Per Pay Amounts		Annual	Staff 24 Per Pay Amounts	Faculty 18 Per Pay Amounts
	<i>Single</i>	\$96.00	\$4.00	\$5.33	<i>Single</i>	\$648.00	\$27.00	\$36.00	<i>Single</i>	\$564.00	\$23.50	\$31.33	<i>Single</i>	\$420.00	\$17.50	\$23.33
	<i>Dual</i>	\$444.00	\$18.50	\$24.67	<i>Dual</i>	\$1,548.00	\$64.50	\$86.00	<i>Dual</i>	\$1,536.00	\$64.00	\$85.33	<i>Dual</i>	\$1,284.00	\$53.50	\$71.33
	<i>Family</i>	\$552.00	\$23.00	\$30.67	<i>Family</i>	\$2,064.00	\$86.00	\$114.67	<i>Family</i>	\$2,064.00	\$86.00	\$114.67	<i>Family</i>	\$1,860.00	\$77.50	\$103.33
BENEFITS	In Network		Out of Network		In Network		Out of Network		In Network		Out of Network		In Network		Out of Network	
Office Visits/Urgent Care Centers	\$20 copay per visit		70% coverage after deductible		\$15 copay per visit		80% coverage after deductible		\$15 copay per visit		Not Covered		\$15 copay per visit or GVHP Urgent Care Center		All other Urgent Care \$25 copay	
Hospital-Emergency Room Care	\$50 copay per visit waived if admitted		\$50 copay per visit waived if admitted		\$50 copay per visit waived if admitted		\$50 copay per visit waived if admitted		\$50 copay per visit waived if admitted		\$50 copay per visit waived if admitted		\$50 copay per visit waived if admitted		\$50 copay per visit waived if admitted	
Routine Physicals, Well Child Care/Immunization/Education and Counseling	\$0 copay per visit		70% coverage after deductible (\$400 annual maximum benefit)		\$0 copay per visit		80% coverage after deductible (\$400 annual maximum benefit)		\$0 copay per visit		Not Covered		\$15 copay per visit (Immunization only, 100% coverage)		Not Covered	
<i>Birth to 2 years:</i>	\$1,700 annual maximum				\$1,700 annual maximum											
<i>2 to 39 years:</i>	\$600 annual maximum				\$600 annual maximum											
<i>40 +:</i>	\$1,000 annual maximum				\$1,000 annual maximum											
Routine Colonoscopy	100% coverage (age 50 and over)		70% coverage after deductible		100% coverage (age 50 and over)		80% after deductible		100% coverage		Not Covered		Covered 100% when deemed medically necessary per GVHP guidelines		Not Covered	
Mental Health Outpatient Care	\$20 copay per visit		70% coverage after deductible		\$15 copay per visit		80% coverage after deductible		All care must be approved by Behavioral Health Department \$15 copay per visit		Not Covered		Short Term Intervention. \$15 copay may apply		Not Covered	
Pregnancy Benefits (Prenatal & Postnatal Care Visits & Delivery Charges)	100% coverage after \$200 service fee		70% coverage after deductible		100% coverage after \$150 service fee		80% coverage after deductible		\$15 copay per visit, max copay \$60 per pregnancy		Not Covered		100% Coverage, no office visit copay		Not Covered	
Pregnancy Benefits (facility charges) (Semi-Private room & Intensive care, surgery, & all related Surgical services, anesthesia, laboratory tests & X-rays, consulting specialists, medicine & drugs, maternity services, and miscellaneous	90% coverage after deductible		70% coverage after deductible		100% coverage		80% coverage after deductible		100% Coverage		Prior Authorization Required		100% coverage		Covered only with prior plan approval unless out of area emergency.	
Chiropractic Services	\$20 copay per visit (\$600 maximum)		70% coverage after deductible (\$600 maximum)		\$15 copay per visit (\$600 maximum)		80% coverage after deductible (\$600 maximum)		\$15 copay up to benefit maximum of 30 visits per member per year. Maximum combined with physical and occupational therapies		Not Covered		\$15 copay, covered up to 20 visits when coordinated through GVHP Integrated Holistic Health (includes acupuncture and massage)		Not Covered	
Outpatient Substance Abuse Treatment	\$20 copay per visit		70% coverage after the deductible		\$15 copay per visit		80% coverage after the deductible		All care must be approved by Behavioral Health Department \$15 copay per visit		Not Covered		\$15 copay may apply		Not Covered	

	<i>GVSU Base PPO</i>		<i>GVSU Enhanced PPO</i>		<i>Priority Health HMO</i>		<i>GVHP HMO</i>	
Nursing Services in the Home	\$20 copay per visit (60 day maximum per period)		\$15 copay per visit (60 day maximum per period)		See home Health Care		See home Health Care	
Home Health Care (In lieu of hospital confinement) Conditions and Limitations Apply	\$20 copay per visit (60 day maximum per period)		\$15 copay per visit (60 day maximum per period)		100% Coverage	Not Covered	Covered in full in lieu of hospitalization	Not Covered
Retail Prescription Drugs (at participating pharmacy)	Administered by Caremark		Administered by Caremark		Administered by Caremark		GVHP Pharmacy Only <i>Excludes Birth Control</i>	
<i>Generic</i>	\$10 copay		\$7 copay		\$7 copay		\$10 copay	
<i>Formulary</i>	\$20 copay		\$15 copay		\$15 copay		\$20 copay	
<i>Name Brand/Non-Formulary</i>	\$30 copay		\$25 copay		\$25 copay		N/A	
<i>Specialty Medications</i>	\$30 copay		\$25 copay		\$25 copay		Varies	
Mail Order Prescription Drugs								
<i>Generic</i>	\$20 copay		\$14 copay		\$14 copay		\$10 copay	
<i>Formulary</i>	\$40 copay		\$30 copay		\$30 copay		\$20 copay	
<i>Name Brand/Non-Formulary</i>	\$60 copay		\$50 copay		\$50 copay		N/A	
<i>Specialty Medications</i>	\$60 copay		\$50 copay		\$50 copay		Varies	
	<i>Generic drugs are mandatory if available.</i>		<i>Generic drugs are mandatory if available.</i>		<i>Generic drugs are mandatory if available.</i>		<i>Generic drugs are mandatory if available.</i>	
Annual Medical Deductible (Copays do not apply)								
<i>Per Individual</i>	\$250	\$500	No Deductible		Not Applicable	Not Applicable	Not Applicable	Not Applicable
<i>Per Family</i>	\$500	\$1,000		\$250				
				\$500				
Annual Out of Pocket Limit (Excludes deductibles, copays & amounts over R&C)								
<i>Per Individual</i>	\$1,000	\$2,500	Not applicable		Not Applicable	Not Applicable	Not Applicable	Not Applicable
<i>Per Family</i>	\$2,000	\$5,000		\$2,000				
				\$4,000				
Semi-Private room & Intensive care, surgery, & all related Surgical services, anesthesia, laboratory tests & X-rays, consulting specialists, medicine & drugs, maternity services, and miscellaneous services	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% coverage	Prior Authorization Required	100% coverage	Covered only with prior plan approval unless out of area emergency.
Outpatient Surgery	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% coverage, prior approval required for certain radiology exams	Not Covered	100% coverage	Not Covered
Laboratory Test, Diagnostic X-Rays, and Allergy Testing	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% Coverage	Not Covered	100% coverage	Prior Authorization Required
Second Surgical Opinion	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% Coverage	Prior Authorization Required	\$15 copay	Prior Authorization Required
Pre-Admission Testing	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% Coverage	Not Covered	100% Coverage	Prior Authorization Required
Ambulance	90% coverage after deductible		100% coverage		100% Coverage	100% Coverage	\$50 copay	\$50 copay
Chemotherapy, Radiation Therapy, Hemodialysis	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% coverage	Not Covered	100% coverage, hemodialysis covered 80%	Not Covered
Physical, Speech, and Occupational Therapy	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	Includes cardiac, pulmonary therapies and spinal manipulation \$15 copay per treatment (30 visits each, per contract year)	Not Covered	\$15 copay. Combined Maximum of 60 visits per contract year	Not Covered

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Inpatient Mental Health and Substance Abuse Care	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% coverage	Not Covered	100% coverage	Not Covered
Voluntary Sterilization (limitations apply)	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% coverage	Not Covered	Not Covered	Not Covered
Extended Care Facility	90% coverage after deductible (120 day maximum per calendar year)	70% after deductible (120 day maximum per calendar year)	100% coverage (120 day maximum per calendar year)	80% after deductible (120 day maximum per calendar year)	100% coverage (45 day maximum per calendar year, combined with Hospice benefit)	Not Covered	100% coverage (45 day maximum per calendar year)	
Hospice	90% coverage		100% coverage		100% coverage (45 day maximum per calendar year, combined with Extended Care Facility benefit)	Not Covered	100% coverage	
Appliances, Prosthetic Devices and Durable Medical Equipment	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	Covered with a 20% copay	Not Covered	DME and Prosthetics at 100%; Orthotics at 50%	Not Covered
Allergy Serum and Injectables	90% coverage after deductible	70% coverage after deductible	100% coverage	80% coverage after deductible	100% coverage, office visit copay may apply	Not Covered	Covered up to \$500	Not Covered
Hearing Care	90% coverage after deductible; exam, evaluation, test and basic hearing aid every 36 months. Maximum benefit payable for all services is \$750 per ear, every 36 months	70% coverage after deductible	Exam, evaluation, test and basic hearing aid every 36 months. Maximum benefit payable for all services is \$750 per ear, every 36 months	80% coverage after deductible	Audiometric exam and hearing exam covered in full. Hearing aid provided once every 36 months, up to \$500 per basic hearing aid.	Not Covered	Audiometric exam and evaluation covered in full up to \$100 per exam. Hearing aid provided once every 36 months, up to \$700 per ear. Basic models only.	Not Covered
Vision Care	\$20 copay, one vision exam every two years. Cost of exam applies to annual preventative care maximum benefit	70% coverage after deductible (limited to \$400 annual maximum benefit, combined for vision, routine physicals, well child care, immunizations, education and counseling)	\$15 copay, one vision exam every two years. Cost of exam applies to annual preventative care maximum benefit	80% coverage after deductible (limited to \$400 annual maximum benefit, combined for vision, routine physicals, well child care, immunizations, education and counseling)	One eye exam (including refraction) with participating provider every two years. Limitations apply	Not Covered	Not Covered	Not Covered
Enrollment of Dependents	Covered to age 19, to age 27 if full-time student		Covered to age 19, to age 27 if full-time student		Covered to age 19, to age 25 if full-time student		Covered to age 19, to age 25 if full-time student	
Temporary Limitation of Benefits for New Hire's with Pre-existing Conditions	No		No		No		No	
Worldwide Coverage	Yes - Refer to Summary Plan Description for definition and details		Yes - Refer to Summary Plan Description for definition and details		Yes - for urgent & emergency care situations		Yes - for urgent & emergency care situations	
Coverage for Employees Age 65+	Yes		Yes		Yes		Yes	
Conversion Option to Personal Policy Upon Termination	No		No		Yes		Yes	
Auto-Insurance Coordination	No		Yes - up to \$1000 per calendar year		Yes		Yes	
Custodial Care (Nursing Home)	Not Covered		Not Covered		Not Covered		Not Covered	
Lifetime Maximum Benefit	\$2 million		\$2 million		No Maximum		No Maximum	

Academic year faculty receive medical plan payroll deductions during the academic year only. Staff and fiscal year faculty receive deductions during the full calendar year. The annual deduction for faculty and staff is the same. Maximums are combined for in and out of network services unless otherwise noted.

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 or by contacting the Benefits Office at 616.331.2220.