GVSU Health Care Plans - Effective January 1, 2024

	GVSU Standard PPO Participates with Priority Health Network (Cigna Wrap Network) Administered by Priority Health				*GVSU High Deductible Health Plan PPO with HSA* Participates with Priority Health Network (Cigna Wrap Network) Administered by Priority Health			
Faculty / Staff Premiums[1]		Annual	Staff 24 Per Pay Amounts	Faculty 18 Per Pay Amounts		Annual	Staff 24 Per Pay Amounts	Faculty 18 Per Pay Amounts
	Single	$1,608.00	$67.00	$89.33	*Single*	$0.00	$0.00	$0.00
	Dual	$3,108.00	$129.50	$172.67	*Dual*	$0.00	$0.00	$0.00
	Family	$4,812.00	$200.50	$264.33	*Family*	$0.00	$0.00	$0.00
BENEFITS	In Network		Out of Network		In Network		Out of Network	
Office Visits/Urgent Care Centers	$20 copay per visit		70% coverage after deductible		100% coverage after deductible		80% coverage after deductible	
Hospital-Emergency Room Care	$50 copay per visit copay waived if admitted		Paid at the Network Benefit level. Reasonable and customary limitations apply.		100% coverage after deductible		Paid at the Network Benefit level. Reasonable and customary limitations apply.	
Virtual Care Services	$20 copay per visit		70% coverage after deductible		100% coverage after deductible		80% coverage after deductible	
Routine Physicals, Well Child Care/Immunization/Education and Counseling	100% coverage. Must follow preventive care guidelines		70% coverage after deductible		100% coverage, deductible does not apply. Must follow preventive care guidelines		80% coverage after deductible	
Routine Colonoscopy	100% coverage. Must follow preventive care guidelines		70% coverage after deductible		Covered 100% (age 50 and over)		80% coverage after deductible	
Services Performed in Physician's Office - Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.	Prior certification required. 100% coverage.		Prior certification required. 70% coverage after deductible.		Prior certification required. 100% coverage after deductible.		Prior certification required. 80% coverage after deductible.	
Outpatient Mental Health and Substance Abuse Care	**All care must be approved by the Behavioral Health Department - (616) 464-8500** $20 copay per visit		70% coverage after deductible		**All care must be approved by the Behavioral Health Department - (616) 464-8500** 100% coverage after deductible		80% coverage after deductible	
Inpatient Mental Health and Substance Abuse Care. Prior Certification required except in emergencies.	**All care must be approved by Behavioral Health Department - (616) 464-8500** 90% coverage after deductible.		70% coverage after deductible.		**All care must be approved by Behavioral Health Department - (616) 464-8500** 100% coverage after deductible.		80% coverage after deductible.	
Pregnancy Benefits	Routine prenatal care covered at 100%.		70% coverage after deductible		Routine prenatal care covered at 100%.		80% coverage after deductible	
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 services)	90% coverage after deductible		70% coverage after deductible		100% coverage after deductible		80% coverage after deductible	
Chiropractic Services	$20 copay per visit up to a maximum of 30 combined in/out of network visits per plan year		70% coverage after deductible, up to a maximum of 30 combined in/out of network visits per plan year		100% coverage after deductible, up to a maximum of 30 combined in/out of network visits per plan year.		80% coverage after deductible, up to a maximum of 30 combined in/out of network visits per plan year	
Private Duty Nursing (combined network and non-network benefit)	$20 copay per visit up to maximum benefit of 60 visits per benefit year. Deductible applies.				100% coverage after deductible, up to a maximum of 60 visits per benefit year.		80% coverage after deductible, up to a maximum of 60 visits per plan year	
Home Health Care. Prior certification required. (In lieu of hospital confinement)	Prior certification required. $20 copay per visit up to a maximum benefit of 60 visits per benefit year. Deductible applies				100% coverage after deductible, up to a maximum of 60 visits per benefit year.		80% coverage after deductible, up to a maximum of 60 visits per plan year	
Non-Hospital Facility Services. Prior certification required, except for hospice facilities. (Including skilled nursing care services received in a: Skilled Nursing Care Facility, Subacute Facility, Inpatient Rehabilityation Facility, Hospice Facility)	90% coverage after deductible (120 day combined in/out of network maximum per plan year)		70% after deductible (120 day combined in/out of network maximum per plan year)		100% coverage after deductible (120 day combined in/out of network maximum per plan year)		80% after deductible (120 day combined in/out of network maximum per plan year)	
Hospice	90% coverage after deductible				100% coverage after deductible		80% coverage after deductible	

[1] Part-time faculty and staff members that were hired before July 1, 2016 should contact the HR Office at 616-331-2215 to confirm medical plan deductions.

BENEFITS	GVSU Standard PPO		GVSU High Deductible Health Plan PPO with HSA	
	In Network	Out of Network	In Network	Out of Network
Retail Prescription Drugs (at participating pharmacy)	Administered by Caremark		Administered by Caremark. *Copays apply after deductible has been met. Annual Rx Copays are capped at $250 for individual and $500 for family.*	
Generic	$4 copay		$4 copay	
Formulary	$20 copay		$20 copay	
Name Brand/Non-Formulary	$40 copay		$40 copay	
Specialty Medications	$40 copay		$40 copay	
Retail 90 Program (90 Day Supply)	3x copay for 90 day supply at retail pharmacy (select drugs only)		3x copay for 90 day supply at retail pharmacy (select drugs only)	
Mail Order Prescription Drugs				
Generic	$8 copay		$8 copay	
Formulary	$40 copay		$40 copay	
Name Brand/Non-Formulary	$80 copay		$80 copay	
Specialty Medications	$80 copay		$80 copay	
	Generic drugs are mandatory if available.		*Generic drugs are mandatory if available.*	
Annual Medical Deductible (Copays do not apply)				
Per Individual	$250	$500	$2,000 [2]	$4,000 [2]
Per Family	$500	$1,000	$4,000 [2]	$8,000 [2]
Annual Coinsurance Maximum (Excludes deductibles, copays & amounts over R&C)				
Per Individual	$1,000	$2,500	N/A	$2,000
Per Family	$2,000	$5,000	N/A	$4,000
Annual Out of Pocket Maximum (Includes deductibles, coinsurance, copays, excludes amounts over R&C)				
Per Individual	$9,450		$2,250	$6,250
Per Family	$18,900		$4,500	$12,500
Semi-Private room & Intensive care, surgery, & all related surgical services, anesthesia, laboratory tests & x-rays, consulting specialists, medicine & drugs, maternity services, & miscellaneous services	Prior certification required except in emergencies and hospital stays for a mother and her newborn. 90% coverage after deductible.	Prior certification required. 70% coverage after deductible.	Prior certification required except in emergencies and hospital stays for a mother and her newborn. 100% coverage after deductible.	Prior certification required. 80% coverage after deductible.
Outpatient Surgery	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Hospital and Freestanding Facility Diagnostic Laboratory and Radiology Services	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Hospital and Freestanding Facility Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.	Prior certification required. 90% coverage after deductible.	Prior certification required. 70% coverage after deductible.	Prior certification required. 100% coverage after deductible.	Prior certification required. 80% coverage after deductible.
Allergy Office Services (includes testing, injections, serum costs)	100% coverage. Deductible does not apply if performed in physician's office.	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Second Surgical Opinion	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Ambulance	90% coverage after deductible	Paid at the Network benefit level. Reasonable and customary limitations apply.	100% coverage after deductible	Paid at the Network benefit level. Reasonable and customary limitations apply.
Chemotherapy, Radiation Therapy, Hemodialysis	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible

[2] The annual deductible for individual coverage is $2,000. For dual, family, or household member coverage the deductible is $4,000. This deductible must be met by any one member or combination of covered members prior to the plan paying.

BENEFITS	*GVSU Standard PPO*		*GVSU High Deductible Health Plan PPO with HSA*	
	In Network	Out of Network	In Network	Out of Network
Physical and Occupational Therapy. Combined Network and Non-Network benefit. (Including aquatic, massage and vision therapy)	90% coverage after deductible up to a benefit plan maximum of 30 visits per plan year	70% coverage after deductible up to a benefit year maximum of 30 visits per plan year	100% coverage after deductible up to a benefit plan maximum of 30 visits per plan year	80% coverage after deductible up to a benefit year maximum of 30 visits per plan year
Vasectomy	90% coverage after deductible.	70% coverage after deductible	100% coverage after deductible.	80% coverage after deductible
Tubal Ligation/Tubal Obstructive Procedures	100% coverage, deductible does not apply when performed at outpatient facilities.	70% after deductible	100% coverage, deductible does not apply when performed at outpatient facilities.	80% after deductible
Appliances, Prosthetic Devices and Durable Medical Equipment. Prior certification required for charges over $1,000.	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
Orthognathic Surgery and Treatment	50% after deductible	50% after deductible	Not Covered	Not Covered
Cochlear Implants	50% after deductible, prior authorization required, Priority Health medical policy applies	50% after deductible, prior authorization required, Priority Health medical policy applies	Not Covered	Not Covered
Services Related to the Treatment of Autism Spectrum Disorder. Physical, Occupational and Speech Therapy; Applied Behavioral Analysis (ABA) for Autism Treatment.	90% after deductible, in and out of network combined, per plan year. Prior approval required.	70% after deductible, in and out of network combined, per plan year. Prior approval required for ABA.	100% after deductible, in and out of network combined, per plan year. Prior approval required.	80% after deductible, in and out of network combined, per plan year. Prior approval required for ABA.
Hearing Care - Combined In Network and Out of Network Benefit.	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	100% 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; exam, evaluation, test and basic hearing aid every 36 months. Maximum benefit payable for all services is $750 per ear, every 36 months
Routine Eye Exam and Glaucoma Testing (does not include refractions unless noted).	100% coverage. One exam each two years.	70% coverage after deductible up to a maximum benefit of $40; one exam each two years.	100% coverage. One exam each two years.	80% coverage after deductible up to a maximum benefit of $40; one exam each two years.
Enrollment of Dependents	Covered up to the end of the month in which they turn age 26 or up to the date they turn 27 if enrolled in a qualified course of study. Over age 26 if mentally or physically incapacitated dependent.		Covered up to the end of the month in which they turn age 26 or up to the date they turn 27 if enrolled in a qualified course of study. Over age 26 if mentally or physically incapacitated dependent.	
Worldwide Coverage	Yes - Refer to Summary Plan Description for definition and details		Yes - Refer to Summary Plan Description for definition and details	
Coverage for Employees Age 65+	Yes		Yes	
Conversion Option to Personal Policy Upon Termination	No		No	
Auto-Insurance Coordination	Not Covered		Not Covered	
Custodial Care (Nursing Home)	Not Covered		Not Covered	
Lifetime Maximum Benefit	Unlimited		Unlimited	

This summary contains the best information available at the time it was written. If any information in it differs from that found in the summary plan description and/or other legal documents describing the topics in this material, the legal descriptions or other documents will prevail. Some of the elements in this plan summary are subject to change due to the Patient Protection and Affordable Care Act/Health Care Reform.