GVSU Health Care Plans - Effective January 1, 2019

	GVSU Standard PPO Participates with Priority Health Network (PHCS Wrap Network) Administered by Priority Health				***GVSU High Deductible Health Plan PPO with HSA*** Participates with Priority Health Network (PHCS 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	$1,416.00	$59.00	$78.67	*Single*	$0.00	$0.00	$0.00
	Dual	$2,748.00	$114.50	$152.67	*Dual*	$0.00	$0.00	$0.00
	Family	$4,248.00	$177.00	$236.00	*Family*	$0.00	$0.00	$0.00
BENEFITS	**In Network**		**Out of Network**		**In Network**		**Out of Network**	
Office Visits/Urgent Care Centers	$20 copy per visit		70% coverage after deductible		100% coverage after deductible		80% coverage after deductible	
Hospital-Emergency Room Care	$50 copy per visit copay waived if admitted		$50 copy per visit copay waived if admitted		100% coverage after deductible			
Virtual Visit (MedNow)	$20 copy per visit		N/A		100% coverage after deductible		N/A	
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 (age 50 and over)		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. $300 penalty if not prior certified.		Prior certification required. 70% coverage after deductible. $300 penalty if not prior certified.		Prior certification required. 100% coverage after deductible. $300 penalty if not prior certified.		Prior certification required. 80% coverage after deductible. $300 penalty if not prior certified.	
Outpatient Mental Health and Substance Abuse Care	**All care must be approved by the Behavioral Health Department - (616) 464-8500** $20 copy 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. $300 penalty if not prior certified.		70% coverage after deductible. $300 penalty if not prior certified.		**All care must be approved by Behavioral Health Department - (616) 464-8500** 100% coverage after deductible. $300 penalty if not prior certified.		80% coverage after deductible. $300 penalty if not prior certified.	
Pregnancy Benefits (Prenatal & Postnatal Care Visits)	Routine prenatal and postnatal care covered at 100%.		70% coverage after deductible		Routine prenatal and postnatal 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 copy per visit up to a maximum of 20 combined in/out of network visits per plan year		70% coverage after deductible, up to a maximum of 20 combined in/out of network visits per plan year		100% coverage after deductible, up to a maximum of 20 combined in/out of network visits per plan year.		80% coverage after deductible, up to a maximum of 20 combined in/out of network visits per plan year	
Nursing Services in the Home	$20 copy 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.			
Home Health Care (In lieu of hospital confinement)	Prior certification required. $20 copy 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.			
Extended Care Facility. Prior certification required.	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. Prior certification required.	90% coverage after deductible				100% coverage after deductible			

[1] Part-time faculty and staff members that were hired before July 1, 2016 should contact the HR Benefits Office at 616-331-2220 or at healthandwellness@gvsu.edu to confirm medical plan deductions.

	GVSU Standard PPO		*GVSU High Deductible Health Plan PPO with HSA*	
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 indivudual 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	$7,900		$2,250	$6,250
Per Family	$15,800		$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. 90% coverage after deductible. $300 penalty if not prior certified.	Prior certification required. 70% coverage after deductible. $300 penalty if not prior certified.	Prior certification required. 100% coverage after deductible. $300 penalty if not prior certified.	Prior certification required. 80% coverage after deductible. $300 penalty if not prior certified.
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. $300 penalty if not prior certified.	Prior certification required. 70% coverage after deductible. $300 penalty if not prior certified.	Prior certification required. 100% coverage after deductible. $300 penalty if not prior certified.	Prior certification required. 80% coverage after deductible. $300 penalty if not prior certified.
Allergy Office Services (includes testing, evaluations, 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		100% coverage after deductible	
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.

	GVSU Standard PPO		*GVSU High Deductible Health Plan PPO with HSA*	
Physical and Occupational 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 - Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.	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 (available for children and adolescents through the age of 18 only). 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; one exam each two years.	100% coverage. One exam each two years.	80% coverage after deductible; 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.	
Temporary Limitation of Benefits for New Hire's with Pre-existing Conditions	No		No	
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.