

# GVSU Health Care Plans - Effective January 1, 2020

Faculty / Staff Premiums <sup>(1)</sup>	<b>GVSU Standard PPO</b>				<b>GVSU High Deductible Health Plan PPO with HSA</b>							
	Participates with Priority Health Network (Cigna Wrap Network)				Participates with Priority Health Network (Cigna Wrap Network)							
	Administered by Priority Health				Administered by Priority Health							
	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			
	Single	\$1,476.00	\$61.50	\$82.00	Single	\$0.00	\$0.00	\$0.00	\$0.00			
	Dual	\$2,856.00	\$119.00	\$158.67	Dual	\$0.00	\$0.00	\$0.00	\$0.00			
	Family	\$4,416.00	\$184.00	\$245.33	Family	\$0.00	\$0.00	\$0.00	\$0.00			
<b>BENEFITS</b>	<b>In Network</b>			<b>Out of Network</b>			<b>In Network</b>			<b>Out of Network</b>		
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			\$50 copay per visit copay waived if admitted			100% coverage after deductible					
Virtual Visit (Spectrum Health Now)	\$20 copay 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	<b>All care must be approved by the Behavioral Health Department - (616) 464-8500</b> \$20 copay per visit			70% coverage after deductible			<b>All care must be approved by the Behavioral Health Department - (616) 464-8500</b> 100% coverage after deductible			80% coverage after deductible		
Inpatient Mental Health and Substance Abuse Care. Prior Certification required except in emergencies.	<b>All care must be approved by Behavioral Health Department - (616) 464-8500</b> 90% coverage after deductible. \$300 penalty if not prior certified.			70% coverage after deductible. \$300 penalty if not prior certified.			<b>All care must be approved by Behavioral Health Department - (616) 464-8500</b> 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 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		
Nursing Services in the Home	\$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.					
Home Health Care (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.					
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					

<sup>(1)</sup> 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 benefitsandwellness@gvsu.edu to confirm medical plan deductions.

	<i>GVSU Standard PPO</i>		<i>GVSU High Deductible Health Plan PPO with HSA</i>	
<b>Retail Prescription Drugs</b> (at participating pharmacy)	Administered by Caremark		Administered by Caremark. <i>Copays apply after deductible has been met. Annual Rx Copays are capped at \$250 for individual and \$500 for family.</i>	
<i>Generic</i>	\$4 copay		\$4 copay	
<i>Formulary</i>	\$20 copay		\$20 copay	
<i>Name Brand/Non-Formulary</i>	\$40 copay		\$40 copay	
<i>Specialty Medications</i>	\$40 copay		\$40 copay	
<i>Retail 90 Program (90 Day Supply)</i>	3x copay for 90 day supply at retail pharmacy (select drugs only)		3x copay for 90 day supply at retail pharmacy (select drugs only)	
<b>Mail Order Prescription Drugs</b>				
<i>Generic</i>	\$8 copay		\$8 copay	
<i>Formulary</i>	\$40 copay		\$40 copay	
<i>Name Brand/Non-Formulary</i>	\$80 copay		\$80 copay	
<i>Specialty Medications</i>	\$80 copay		\$80 copay	
	<i>Generic drugs are mandatory if available.</i>		<i>Generic drugs are mandatory if available.</i>	
<b>Annual Medical Deductible</b> (Copays do not apply)				
<i>Per Individual</i>	\$250	\$500	\$2,000 <sup>(2)</sup>	\$4,000 <sup>(2)</sup>
<i>Per Family</i>	\$500	\$1,000	\$4,000 <sup>(2)</sup>	\$8,000 <sup>(2)</sup>
<b>Annual Coinsurance Maximum</b> (Excludes deductibles, copays & amounts over R&C)				
<i>Per Individual</i>	\$1,000	\$2,500	N/A	\$2,000
<i>Per Family</i>	\$2,000	\$5,000	N/A	\$4,000
<b>Annual Out of Pocket Maximum</b> (Includes deductibles, coinsurance, copays, excludes amounts over R&C)				
<i>Per Individual</i>	\$8,150		\$2,250	\$6,250
<i>Per Family</i>	\$16,300		\$4,500	\$12,500
<b>Semi-Private room &amp; Intensive care, surgery, &amp; all related surgical services, anesthesia, laboratory tests &amp; x-rays, consulting specialists, medicine &amp; drugs, maternity services, &amp; miscellaneous services</b>	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.
<b>Outpatient Surgery</b>	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
<b>Hospital and Freestanding Facility Diagnostic Laboratory and Radiology Services</b>	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
<b>Hospital and Freestanding Facility Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies.</b>	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.
<b>Allergy Office Services (includes testing, evaluations, injections, serum costs)</b>	100% coverage. Deductible does not apply if performed in physician's office.	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
<b>Second Surgical Opinion</b>	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
<b>Ambulance</b>	90% coverage after deductible		100% coverage after deductible	
<b>Chemotherapy, Radiation Therapy, Hemodialysis</b>	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible

<sup>(2)</sup> 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.

	<i>GVSU Standard PPO</i>		<i>GVSU High Deductible Health Plan PPO with HSA</i>	
<b>Physical, Vision and Occupational Therapy</b>	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
<b>Vasectomy - Covered only when performed in physician's office or when in connection with other covered inpatient or outpatient surgery.</b>	90% coverage after deductible.	70% coverage after deductible	100% coverage after deductible.	80% coverage after deductible
<b>Tubal Ligation/Tubal Obstructive Procedures</b>	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
<b>Appliances, Prosthetic Devices and Durable Medical Equipment. Prior certification required for charges over \$1,000.</b>	90% coverage after deductible	70% coverage after deductible	100% coverage after deductible	80% coverage after deductible
<b>Orthognathic Surgery and Treatment</b>	50% after deductible	50% after deductible	Not Covered	Not Covered
<b>Cochlear Implants</b>	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
<b>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.</b>	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.
<b>Hearing Care - Combined In Network and Out of Network Benefit.</b>	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
<b>Routine Eye Exam and Glaucoma Testing (does not include refractions unless noted).</b>	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.
<b>Enrollment of Dependents</b>	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.	
<b>Temporary Limitation of Benefits for New Hire's with Pre-existing Conditions</b>	No		No	
<b>Worldwide Coverage</b>	Yes - Refer to Summary Plan Description for definition and details		Yes - Refer to Summary Plan Description for definition and details	
<b>Coverage for Employees Age 65+</b>	Yes		Yes	
<b>Conversion Option to Personal Policy Upon Termination</b>	No		No	
<b>Auto-Insurance Coordination</b>	Not Covered		Not Covered	
<b>Custodial Care (Nursing Home)</b>	Not Covered		Not Covered	
<b>Lifetime Maximum Benefit</b>	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.*