

Saginaw Valley State University Support Staff Group Health Insurance Comparison Chart 2010-2011

The following chart provides an overview of the Support Staff Health Insurance Plans offered by SVSU. It is not intended to be a full description of coverage. Please refer to the Plan Benefits Summary for detailed information.

	Health Plus (POS)			Health Plus (HMO)			BCBS (PPO)-Plan 1			BCBS Community Blue PPO-Plan 4		
							In-Network	Out-of-Network		In-Network	Out-of-Network	
Customer Service Numbers	1-800-332-9161			1-800-332-9161			1-800-258-8000			1-800-258-8000		
Group Numbers	318100			318100			68859			68859		
Coverage:	Total:	University Contribution:	Employee	Total:	University:	Employee	Total:	University Contribution:	Employee	Total:	University	Employee
Single Coverage	\$464.17	\$464.17	\$0	\$819.34	\$675.00	\$144.34	\$524.03	\$524.03	\$0	\$421.15	\$421.15	\$0
2-Person Coverage	\$991.48	\$991.48	\$0	\$1750.15	\$1046.00	\$704.15	\$1257.71	\$1046.00	\$211.71	\$1010.81	\$1010.81	\$0
Family Coverage	\$1137.26	\$1137.26	\$0	\$2007.45	\$1185.00	\$822.47	\$1572.07	\$1185.00	\$387.07	\$1263.41	\$1185.00	\$78.41
Plan Features:												
Plan Maximums:												
Individual Deductible	NONE		NONE	NONE			\$0		\$250	\$500		\$1,000
Family Deductible	NONE		NONE	NONE			\$0		\$500	\$1,000		\$2,000
Individual Out-of-Pocket Max	NONE		\$1,500	NONE			\$0		\$2,000	\$1,500		\$3,000
Family Out of Pocket Max	NONE		\$3,000	NONE			N/A		\$4,000	\$3,000		\$6,000
Physicians Services:												
Office Visits	\$20 co-pay		20% co-pay	\$0 co-pay			\$20 co-pay		Covered - 80% after deductible, must be medically necessary	\$20 co-pay		60% Covered
Periodic Physical Exams and Preventative Health Visits	\$20 co-pay		20% co-pay	\$0 co-pay			Covered 100%, one per calendar year, includes select lab and Diagnostic procedures***		Not Covered	Health Maintenance: 100% Covered		Health Maintenance: Not Covered
Mammography	\$0 co-pay		Lab and Radiology - 20% co-pay	\$0 co-pay			Covered 100%		Covered - 80% after deductible	80% Covered		60% Covered
							One per calendar year, no age restrictions					
Maternity Care, including Prenatal and Postpartum Care	\$0 co-pay		20% co-pay	\$0 co-pay			Covered 100%		Covered 80% - after deductible	100% Covered		60% Covered
Well-Baby and Child Care	\$20 co-pay		20% co-pay	\$0 co-pay			Covered 100%		Not Covered	100% Covered 6 visits: birth-35 months 2 visits: 36-47months 1 visit: 47+		Not Covered
Immunizations	\$0 co-pay		20% co-pay	\$0 co-pay			Covered 100% up to age 16		Not Covered	N/A		N/A
Allergy Services	\$0 co-pay		20% co-pay	\$0 co-pay			Covered 100%		Covered - 80% after deductible	Covered- 100%		Covered- 60% after deductible

	Health Plus POS		Health Plus (HMO)	BCBS Community Blue (PPO)		BCBS Community Blue PP0-Plan 4	
				In-Network	Out-of-Network	In-Network	Out-of-Network
Customer Service Numbers	1-800-332-9161		1-800-332-9161	1-800-258-8000		1-800-258-8000	
Group Numbers	318100		318100	68859		68859	
Inpatient Hospital Services:							
Inpatient Hospital	\$0 co-pay	20% co-pay*	\$0 co-pay	Covered 100%	Covered - 80% after deductible	80% Covered	60% Covered
				Unlimited Days			
Inpatient Surgery	\$0 co-pay	20% co-pay	\$0 co-pay	Covered 100%	Covered - 80% after deductible	80% Covered	60% Covered
Outpatient Hospital:							
Outpatient Surgery	\$0 co-pay	20% co-pay	\$0 co-pay	Covered 100%	Covered - 80% after deductible		
Outpatient Lab & X-Ray	\$0 co-pay	Radiology - 20% co-pay	\$0 co-pay	Covered 100%	Covered - 80% after deductible	Covered - 80% after deductible	Covered- 60% after deductible
Emergency Services:							
Urgent Care Facility	\$25	\$25	\$0 if treated within 24 hours of injury, or when authorized by a Plan Physician. \$15 Co-pay per visit for other use.	Covered - \$20 co-pay	Covered - 80% after deductible, must be medically necessary	\$20 co-pay	60% Covered(after deductible and must be medically necessary)
			Out-of-Area - \$0 Co-pay				
Emergency Room	\$100 \$0 if admitted	\$100 \$0 if admitted	In Area - \$0 when admitted to Hospital. \$15 Co-payment per Visit for other use.	Covered - \$100 co-pay, waived if admitted or for an accidental injury	Covered - \$100 co-pay, waived if admitted or for an accidental injury	\$150 co-pay (Co-pay waived if admitted or for an accidental injury)	\$150 co-pay (Co-pay waived if admitted or for an accidental injury)
			Out-of-Area - \$0 Co-payment				
Ambulance	\$25	\$25	\$0 for Co-payment for immediate transportation in conjunction with and accident or other life threatening situation, or when authorized in advance by Health Plus. \$25 Co-payment per occurrence for other use.	Covered 100%	Covered 100%	80% Covered (Must be medically necessary)	80% Covered (Must be medically necessary)
Mental Health and Substance Abuse Treatment:							
Inpatient Mental Health Care	\$0 co-pay	50% co-pay*	\$0 co-pay	Covered 80%	Covered 50% after deductible	Covered - 80% after deductible	Covered- 80% after deductible
	Limited to 60 days per member per calendar year			Unlimited days			

	Health Plus POS		Health Plus (HMO)	BCBS Community Blue (PPO)		BCBS Community Blue PP0-Plan 4	
				In-Network	Out-of-Network	In-Network	Out-of-Network
Customer Service Numbers	1-800-332-9161		1-800-332-9161	1-800-258-8000		1-800-258-8000	
Group Numbers	318100		318100	68859		68859	
Mental Health and Substance Abuse Treatment Cont....:							
Inpatient Substance Abuse Care	\$0 co-pay	50% co-pay*	\$0 co-pay	Covered 80%	Covered 50% after	Covered - 80% after deductible	
				Up to \$15,000 annually and \$30,000 lifetime for substance abuse		Up to \$15,000 annually and \$30,000 lifetime for substance	
Outpatient Mental Health Care	\$20 co-pay	50% co-pay	\$10 co-pay	Facility, Clinic, and Physician's Office - Covered 80%	Facility and Clinics - Covered 50%	Covered - 80% after deductible	
					Physicians Office - Covered 50% after deductible		
Outpatient Substance Abuse Care	\$20 co-pay	50% co-pay	\$10 co-pay	Covered 80%	Covered 50% after deductible	Covered - 80% after deductible (Up to the state-dollar amount that is adjusted annually)	
Prescription Drugs:							
Generic	\$10 co-pay	NA	\$0 co pay	\$10 co-pay	\$10 co-pay	\$10 co-pay	\$10 co-pay
Brand Name	\$40 co-pay	NA	\$0 co pay	\$40 co-pay	\$40 co-pay	\$40 co-pay	\$40 co-pay
Fertility Drugs	50%	NA					
Mail Order	A 90 day supply is available at Participating Retail Pharmacies through the "As for 90" program or by Mail Order Service through Express Scripts for two co-payments.	NA	A 90 day supply is available at Participating Retail Pharmacies through the "As for 90" program or by Mail Order Service through Express Scripts for two co-payments.	\$20 co-pay for Generic/ \$80 co-pay for Brand Name	\$20 co-pay for Generic/ \$80 co-pay for Brand Name	\$20 co-pay for Generic/ \$80 co-pay for Brand Name	\$20 co-pay for Generic/ \$80 co-pay for Brand Name
Miscellaneous Services:							
Home Health Care	\$0 co-pay	50% co-pay	\$0 co-pay	Covered 100%	Covered 100%	Covered- 80% after deductible	Covered- 80% after deductible
				Unlimited Visits			
Skilled Nursing	\$0 co-pay	50% co-pay	\$0 co-pay	Covered 100%	Covered 100%	Covered- 50% (Private Duty Nursing)	Covered- 50% (Private Duty Nursing)
				Limited to 730 days per member per lifetime			
Hospice	\$0 co-pay	\$0 co-pay	\$0 co-pay	Covered 100%	Covered 100%	Covered- 100% (Up to 28 pre-hospice counseling visits/ 4-90 days periods in hospice)	
				Limited to dollar maximum which is adjusted periodically			
Durable Medical Equipment	\$0 co-pay	50% co-pay	\$0 co-pay	Covered - 100%	Covered - 100%	Covered- 80%	Covered- 80% after deductible

Additional Health Plans:

BCBS Traditional:						
	Customer Service Number	Group Number	Individual Deductible	Family Deductible	Ind. Out-of-Pocket Max	Family Out-of-Pocket Max
	1-800-258-8000	68859	Basic Coverage \$0 Master Medical - \$50	Basic Coverage \$0 Master Medical - \$100	Basic - NONE	Master Medical - \$1000 Family
	Office Visits	Periodic Physical Exams & Preventative Health Exams	Mammography	Maternity Care(Prenatal & Postpartum)	Well-Baby and Child Care	Immunizations
	Covered 90% under master medical after deductible	Not Covered	Covered (one per year)	Covered 100%	Not Covered	Not Covered
	Allergy Services	Inpatient Hospital	Inpatient Surgery	Outpatient Surgery	Outpatient Lab and X-Ray	Urgent Care Facility
	Covered 90% under master medical after deductible	Covered up to 365 days, 60-day renewal, additional days under MM AT 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
	Emergency Room	Ambulance	Inpatient Mental Health Care	Inpatient Substance Abuse	Outpatient Mental Health	Outpatient Substance Abuse Care
	Covered 100%	Covered	Covered 100%, up to 45 days. 60-day renewal, additional days under MM at 75% after deductible	Covered 100%, unused mental health care days, no MM coverage	Covered 75% under MM after deductible	Covered 100%-up to the state-dollar amount, which is adjusted annually
	Generic Brand Prescriptions	Brand Name Prescriptions	Fertility Drug Prescriptions	Mail Order Prescriptions	Home Health Care	Skilled Nursing
	\$20 co-pay	\$20 co-pay	N/A	N/A	Covered 100%	Covered up to 730 days
		Hospice	Durable Medical Equipment			
		Covered 100%	Covered 90% under MM after deductible			

* Hospital Coverage for level 2 shall be reduced by \$500 for each hospital admission which is not authorized either in advance, or within 24-hours of an emergency admission.

** not covered at non-affiliated pharmacies