

Saginaw Valley State University Support Staff Group Health Insurance Comparison Chart 2012

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 (PPO1)-Plan 1			BCBS Community Blue PPO-Plan 3		
	In-Network (PCP Directed)	Out-of-Network (Self Directed)					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	\$519.44	\$ 519.44	\$ 0.00	\$916.62	\$ 700.00	\$ 216.62	\$610.32	\$610.32	\$ 0.00	\$429.69	\$429.69	\$ 0.00
2-Person Coverage	\$1109.54	\$1100.00	\$ 9.54	\$1958.57	\$1100.00	\$ 858.57	\$1464.76	\$1100.00	\$364.76	\$1031.24	\$1031.24	\$ 0.00
Family Coverage	\$1272.68	\$1245.00	\$27.68	\$2246.54	\$1245.00	\$1001.54	\$1830.95	\$1245.00	\$585.95	\$1289.05	\$1245.00	\$44.05
							BCBS (PPO1)-Plan 2					
Coverage:	Total:	University Contribution:	Employee	Total:	University:	Employee	Total:	University Contribution:	Employee	Total:	University	Employee
Single Coverage							\$521.45	\$ 521.45	\$ 0.00			
2-Person Coverage							\$1251.46	\$1100.00	\$151.46			
Family Coverage							\$1564.33	\$1245.00	\$319.33			
Plan Features:												
Plan Maximums:												
Individual Deductible	NONE		NONE		NONE		\$0		\$250	\$250		\$500
Family Deductible	NONE		NONE		NONE		\$0		\$500	\$500		\$1,000
Individual Out-of-Pocket Max	NONE		\$1,500		NONE		\$0		\$2,000	\$1,000		\$3,000
Family Out of Pocket Max	NONE		\$3,000		NONE		N/A		\$4,000	\$2,000		\$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	\$25 co-pay		60% Covered
Periodic Physical Exams and Preventative Health Visits	\$0 co-pay		20% co-pay		\$0 co-pay		Covered 100%, one per calendar year		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%	Covered 100%		60% Covered
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	\$0 co-pay		20% co-pay		\$0 co-pay		Covered 100% up to age 16		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%		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
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	\$25 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	20% co-pay*	\$0 co-pay	Covered 80%	Covered 80% after deductible	Covered - 80% after deductible	Covered- 60% after deductible
Inpatient Substance Abuse Care	\$0 co-pay	20% co-pay*	\$0 co-pay	Covered 80%	Covered 80% after deductible	Covered - 80% after deductible	
				Unlimited days up to \$15,000 annually and \$30,000 lifetime for substance abuse		Unlimited days p to \$15,000 annually and \$30,000 lifetime for substance abuse	
Outpatient Mental Health Care	\$20 co-pay	20% co-pay	\$10 co-pay	Covered 80% after deductible	Covered 80% - after deductible	Covered - 80% after deductible	

Care	Limited to 60 visits per member per calendar year			deductible	after deductible		
Outpatient Substance Abuse Care	\$20 co-pay	20% co-pay	\$10 co-pay	Covered 80%	Covered 80% after deductible	Covered - 80% after deductible (Up to the state-dollar amount that is adjusted annually)	
Prescription Drugs:				PPO1 - Plan 1			
Generic	\$10 generic	NA	\$0 co pay	Tier 1 - \$15	Tier 1 - \$15		
Brand Name	\$40 Brand	NA	\$0 co pay	Tier 2 - \$50	Tier 2 - \$50		
Fertility Drugs	50%	NA		Tier 3 - 50%	Tier 3 - 50%		
				PPO1 - Plan 2		PPO3	
Generic				Tier 1 - \$15	Tier 1 - \$15	Tier 1 - \$15	Tier 1 - \$15
Brand Name				Tier 2 - \$50	Tier 2 - \$50	Tier 2 - \$50	Tier 2 - \$50
Tier 3 Non-Brand Formulary (Min = \$70; Max. = \$100)				Tier 3 - 50%	Tier 3 - 50%	Tier 3 - 50%	Tier 3 - 50%
Mail Order	90-day supply	NA	90-day supply	90-day supply	*Refer to the Benefits at a Glance	90-day supply	*Refer to the Benefits at a Glance
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
Skilled Nursing	\$0 co-pay	50% co-pay	\$0 co-pay	Covered 100%	Covered 100%	Covered- 80% (Private Duty Nursing)	Covered- 50% (Private Duty Nursing)
	Limited to 730 days per member per lifetime			Up to 120 days per calendar year			
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

Benefits-at-a-Glance

<http://www.svsu.edu/hr/home/open-enrollment-introduction.html>