FERRIS STATE UNIVERSITY

HUMAN RESOURCES

Benefits at a Glance

2024-2025

AFSCME

CONTACT US NOW

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Human Resources

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NEW HIRE ENROLLMENT

Benefits are available on the date of hire into a full-time AFSCME position. Newly benefit eligible employees have 30 calendar days to enroll in FSU benefit plans.

MEDICAL/PRESCRIPTION

FSU offers 5 medical/prescription plan options through Priority Health including PPO, EPO, and HDHP options. Employees may also elect to opt-out of an FSU medical plan, if they have other coverage, and may receive an opt-out credit.

DENTAL

FSU offers 2 dental plan options through Blue Cross Blue Shield Dental. The low plan is provided at no cost for employees and dependents. The high plan, which has a cost, includes orthodontic coverage for adults. Employees may elect to opt-out of an FSU dental plan, if covered elsewhere, and receive an opt-out credit.

VISION

FSU offers 2 vision coverage plan options through EyeMed. The core plan is available at no cost for employees and their dependents.

OTHER ELIGIBLE ADULT

Employees may enroll one "other eligible adult" (OEA) in an FSU-sponsored health care plan if they have resided in the same residence as the employee for at least the last 18 months and are not a dependent of the employee as defined by the IRS.

FLEXIBLE SPENDINGS ACCOUNTS

Pre-tax deductions to a Medical Flexible Spending Account (up to $3,200 per plan year) for employees enrolled in Ferris 1, 2, or 3.

Pre-tax deductions to a Dependent Care Flexible Spending Account (up to $5,000 per plan year) for all benefit eligible employees.

LIFE INSURANCE

$25,000 Group Term Life and AD&D Insurance at no cost to the employee. Additional supplemental insurance can be purchased up to 5x the employee's annual base salary (maximum coverage $650,000).

There are also 2 Voluntary Dependent Life insurance options available to purchase as well.

LONG TERM DISABILITY

After 90 days of disability, LTD pays 66 2/3% of the employee's monthly salary to age 65 or until the end of disability, whichever occurs first. An option to decrease the waiting period to 60 days is available for a cost.

TUITION WAIVER

Employees are eligible to take up to nine (9) FSU credits per semester, 24 maximum per year, under-graduate or graduate, at no cost. Credits may be transferred to a spouse and/or dependent child.

This benefit may be taxable based on the current IRS guidelines.

Spouse and/or dependent child may receive a 30% tuition discount in lieu of credit waivers.

RETIREMENT

FSU contributes 10% of the employee's base salary to a 403b account each pay period. Employee's have a mandatory 4% contribution. Employees may make voluntary contributions via payroll deduction as well. There is an 8 year vesting schedule for the employer contributions.

FSU retirement plans are processed through TIAA-CREF.

Employees with previous university service in the Michigan Public Schools Employee Retirement System are eligible to continue their MPSERS retirement plan.

Paid Time Off

SICK TIME

Employees accrue sick time at a rate of 4.0 hours per pay and is available for use by the employee upon employment.

Employees may accrue up to a maximum of 1,040 sick hours.

VACATION TIME

Vacation time is available for use by the employee after six (6) months of continuous employment.

Vacation is accrued on a per pay period basis according to length of continuous service:

Any unused vacation hours in excess of the employee's annual accrual maximum for the year will be forfeited annually on the employee's anniversary date.

Length of Service	Per Pay Period Accrual	Annual Max Accrual
1 year through 4 years	3.69 hours	96 hours / year
5 years through 9 years	4.62 hours	120 hours / year
10 years or more	6.15 hours	160 hours / year

HOLIDAYS

After 10 days of employment, employees receive the following days off as paid holidays:

New Year's Day
MLK Day
Good Friday
Memorial Day
July 4th
Labor Day
Thanksgiving Day
Day after Thanksgiving
Christmas Eve
Christmas Day
New Year's Eve

Additional paid holiday time may be granted by the President.

PERSONAL TIME

Employees receive 2 personal days (16 hours) at the beginning of each plan year (July 1). 8 hours of personal time are chargeable to sick time. Unused personal hours will not carry over into the next plan year.

Personal time is available for use by the employee after six (6) months of continuous employment.

FERRIS STATE UNIVERSITY

FERRIS FORWARD

Ferris State University
Priority Health Plan Design Change Summary
2024-2025 Plan Year

AFSCME COSTS

	FERRIS 1 Not Open to New Enrollment, *PPO Plan*		FERRIS 2 *EPO Plan*		FERRIS 3 *PPO Plan*		FERRIS 4 (HSA) *PPO Plan with HSA*		FERRIS 5 (HSA) *PPO Plan with HSA*	
	IN NETWORK	OUT OF NETWORK	IN NETWORK		IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Preventive Care	100% coverage	70% after deductible	100% coverage		100% coverage	60% after deductible	100% coverage	80% after deductible	100% coverage	80% after deductible
Primary Care Office Visit (face to face and telehealth)	$25 copay	70% after deductible	$25 copay		$25 copay	60% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Specialist Office Visit (face to face and telehealth)	$50 copay	70% after deductible	$50 copay		$50 copay	60% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Virtual Care Services (Spectrum Health or MDLive acute virtual care)	$0 copay	N/A	$0 copay		$0 copay	N/A	100% after deductible ($49 charge)	N/A	100% after deductible ($49 charge)	N/A
Coinsurance - (Plan Pays)	90% after ded.	70% after deductible	90% after deductible		80% after deductible	60% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Prescription copay							*COPAYS APPLY AFTER DEDUCTIBLE*		*COPAYS APPLY AFTER DEDUCTIBLE*	
Generic	20% copay ($5 min/$30 max)		20% copay ($5 min/$30 max)		20% copay ($5 min/$30 max)		10% copay ($5 min/$30 max)		10% copay ($5 min/$30 max)	
Preferred Brand	20% copay ($30 min/$60 max)		20% copay ($30 min/$60 max)		20% copay ($30 min/$60 max)		10% copay ($30 min/$60 max)		10% copay ($30 min/$60 max)	
Non-Preferred Brand	20% copay ($50 min/$75 max)		20% copay ($50 min/$75 max)		20% copay ($50 min/$75 max)		10% copay ($50 min/$75 max)		10% copay ($50 min/$75 max)	
Preferred Specialty	20% copay ($40 min/$70 max)		20% copay ($40 min/$70 max)		20% copay ($40 min/$70 max)		10% copay ($40 min/$70 max)		10% copay ($40 min/$70 max)	
Non-Preferred Specialty	20% copay ($80 min/$100 max)		20% copay ($80 min/$100 max)		20% copay ($80 min/$100 max)		10% copay ($80 min/$100 max)		10% copay ($80 min/$100 max)	
Mail Order Pharmacy	*1x copay for 90 day supply*		*1x copay for 90 day supply*		*1x copay for 90 day supply*		*1x copay for 90 day supply*		*1x copay for 90 day supply*	
Urgent Care Center Copay	$50 copay	70% after deductible	$50 copay		$50 copay	60% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Emergency Room Copay							100% after deductible		100% after deductible	
Network										
Deductible										
Individual	$750	$1,500	$750		$1,000	$2,750	$1,750	$3,500	$3,000	$6,000
Family	$1,500	$3,000	$1,500		$2,000	$5,500	$3,500	$7,000	$6,000	$12,000
Coinsurance Maximum	*Excludes Deductible*		*Excludes Deductible*		*Excludes Deductible*		*Excludes Deductible*		*Excludes Deductible*	
Individual	$1,750	$3,500	$1,750		$2,250	$2,750	$1,000	$2,500	$2,000	$4,000
Family	$3,500	$7,000	$3,500		$4,500	$5,500	$2,000	$5,000	$4,000	$8,000
Out of Pocket Maximum	*Includes Deductibles, Coinsurance*		*Includes Deductibles, Coinsurance*		*Includes Deductibles, Coinsurance*		*Includes Deductibles, Coinsurance,* ***Copays***		*Includes Deductibles, Coinsurance,* ***Copays***	
Individual	$2,500	$5,000	$2,500		$3,250	$5,500	$2,750	$6,000	$5,000	$10,000
Family	$5,000	$10,000	$5,000		$6,500	$11,000	$5,500	$12,000	$10,000	$20,000
ACA Statutory Maximum	*Includes Deductibles, Coinsurance,* ***Copays***		*Includes Deductibles, Coinsurance,* ***Copays***		*Includes Deductibles, Coinsurance,* ***Copays***		*Includes Deductibles, Coinsurance,* ***Copays***		*Includes Deductibles, Coinsurance,* ***Copays***	
Individual	$9,450	$18,900	$9,450		$9,450	$18,900	$2,750	$6,000	$5,000	$10,000
Family	$18,900	$37,800	$18,900		$18,900	$37,800	$5,500	$12,000	$10,000	$20,000
AFSCME COSTS	**Per Pay Cost**	**Annual Cost**	**Per Pay Cost**	**Annual Cost**	**Per Pay Cost**	**Annual Cost**	**Per Pay Cost**	**Annual Cost**	**Per Pay Cost**	**Annual Cost**
Single	*$140.93*	*$3,664.18*	*$137.47*	*$3,574.22*	*$53.30*	*$1,385.80*	*$41.52*	*$1,079.52*	*$18.64*	*$484.64*
2 Person	*$257.39*	*$6,692.14*	*$248.93*	*$6,472.18*	*$175.01*	*$4,550.26*	*$121.99*	*$3,171.74*	*$54.52*	*$1,417.52*
Family	*$357.79*	*$9,302.54*	*$346.91*	*$9,019.66*	*$200.83*	*$5,221.58*	*$137.27*	*$3,569.02*	*$54.94*	*$1,428.44*
							HSA Contribution	**Annual Amount**	**HSA Contribution**	**Annual Amount**
							Single	*$500.00*	Single	*$500.00*
							2 Person	*$1,000.00*	2 Person	*$1,000.00*
							Family	*$1,250.00*	Family	*$1,250.00*

Blue Cross Blue Shield Dental Plan Options

		Low Plan	High Plan
Preventative Care	Cleanings (Limit) Fluoride (Limit) Oral Exams Sealants X-Rays	80% (2 in 12 Months) 80% (Under Age 19) 80% 80% 80%	100% (2 in 12 Months) 100% (Under Age 19) 100% 100% 100%
Basic Care	Anesthesia Fillings Period Surgery Perio Maintenance (Limit) Repair of Crowns, Bridges, & Dentures Root Canal Scaling/Root Planing Simple Extractions Surgical Extractions	60% 60% 60% 60% (Once Every 3 Months) 60% 60% 60% 60% 60%	80% 80% 80% 80% (Once Every 3 Months) 80% 80% 80% 80% 80%
Major Care	Bridges & Dentures Dental Implants Inlays, Onlays, Veneers Single Crowns	50% 50% 50% 50%	80% 80% 80% 80%
Orthodontia	Orthodontia (Limit) Lifetime Max Benefit (Per Member)	50% (Under Age 19) $1,000	50% (Any Age) $1,500
	Annual Max Benefit (Per Member)	$1,000	$1,200
	Dental Premiums Per Pay Period	$0 - Single, Two Person & Family	$5.96/pay - Single $8.92/pay - Two Person $20.85/pay - Family

If you select no dental coverage, and are not covered on another employee's FSU dental plan (through a spouse, parent or OEA relationship) you will receive an opt out credit of $163/year paid at $6.27 per pay period.

This is not a comprehensive list of covered dental services and/or exclusions. Please ask your dental provider to complete a Pre-Determination for all non-routine dental care to determine actual dental insurance coverage.

EyeMed Vision Plan Options

Ferris State University — CORE PLAN

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option Base

Exam & Materials

Insight Network

Fully Insured

Employer Paid

Funded Benefits

Frequency

Examination
Once every 12 months

Lenses (in lieu of contacts)
Once every 12 months

Contacts (in lieu of lenses)
Once every 12 months

Frame
Once every 12 months

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$0 copay	Up to $40
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $91
CONTACT LENSES		
(Contact Lens allowance includes materials only)		
Contacts - Conventional	$0 copay; 15% off balance over $110 allowance	Up to $110
Contacts - Disposable	$0 copay; 100% of balance over $110 allowance	Up to $110
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $300
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $30
Bifocal	$10 copay	Up to $50
Trifocal	$10 copay	Up to $70
Lenticular	$10 copay	Up to $70
Progressive - Standard	$75 copay	Up to $50
Progressive - Premium Tier 1	$95 copay	Up to $50
Progressive - Premium Tier 2	$105 copay	Up to $50
Progressive - Premium Tier 3	$120 copay	Up to $50
Progressive - Premium Tier 4	$75 copay, 20% off retail price less $120 allowance	Up to $50

Vision Premiums Per Pay Period
Single: $0
Two Person: $0
Family: $0

Ferris State University — BUY UP PLAN

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option Buy Up

Exam & Materials

Insight Network

Fully Insured

Employee Paid

Funded Benefits

Frequency

Examination
Once every 12 months

Lenses (in lieu of contacts)
Once every 12 months

Contacts (in lieu of lenses)
Once every 12 months

Frame
Once every 12 months

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMEN
EXAM SERVICES		
Exam	$0 copay	Up to $40
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $105
CONTACT LENSES		
(Contact Lens allowance includes materials only)		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $150
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $150
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $300
STANDARD PLASTIC LENSES		
Single Vision	$0 copay	Up to $30
Bifocal	$0 copay	Up to $50
Trifocal	$0 copay	Up to $70
Lenticular	$0 copay	Up to $70
Progressive - Standard	$65 copay	Up to $50
Progressive - Premium Tier 1	$85 copay	Up to $50
Progressive - Premium Tier 2	$95 copay	Up to $50
Progressive - Premium Tier 3	$110 copay	Up to $50
Progressive - Premium Tier 4	$65 copay, 20% off retail price less $120 allowance	Up to $50

Vision Premiums Per Pay Period
Single: $2.32
Two Person: $4.41
Family: $6.47