

Health Plans Coverage Summary

Benefit	Community Blue		Blue Care Network		BCBSM Transition Plan ⁽³⁾
	In-Network	Out-of-Network	In-Network	Out-of-Network	Mixed Medicare ONLY
PREVENTIVE SERVICES					
Health Maintenance Exam	Covered 100% ⁽¹⁾ 1 per calendar year	Not covered	Covered 100%	Not covered	Covered 100%
Annual Gynecological Exam	Covered 100% 1 per calendar year	Not covered	Covered 100%	Not covered	Covered 100%
Pap Smear Screening (lab services only)	Covered 100% 1 per calendar year	Not covered	Covered 100%	Not covered	Covered 100%
Mammography Screening	Covered 100% 1 per calendar year Subject to faculty deductible ⁽²⁾	Covered 80% after deductible	Covered 100%	Covered 80% of eligible expenses after deductible ⁽⁴⁾ Prior authorization may be required	Covered 100%
Contraceptive Devices (IUD, Diaphragm, Norplant)	Co-pay: \$20	Covered 80% after deductible	Co-pay: \$20	Not covered	Not covered
Well-Baby and Child Care Exams	Covered 100%	Not covered	Covered 100%	Not covered	Covered 100%
Immunizations	Covered 100%	Not covered	Covered 100%	Not covered	Covered 100%
Flu Shots	Covered 100%	Not covered	Covered 100%	Covered 100%	Covered 100%
Fecal Occult Blood Screening	Covered 100% 1 per calendar year	Not covered	Covered 100%	Not covered	Covered 100% 1 per calendar year
Colonoscopy	Covered 100% Subject to faculty deductible ⁽²⁾	Covered 80% after deductible	Covered 100%	Covered 80% of eligible expenses after deductible ⁽⁴⁾ Prior authorization may be required	Covered 100%
Flexible Sigmoidoscopy Exam	Covered 100% 1 per calendar year	Not covered	Covered 100%	Not covered	Covered 100% 1 per calendar year
Prostate Exam	Covered 100% 1 per calendar year age 40 and up	Not covered	Covered 100%	Not covered	Covered 100% 1 per calendar year age 40 and up
Prostate Specific Antigen (PSA) Screen	Covered 100% 1 per calendar year age 40 and up	Not covered	Covered 100%	Not covered	Covered 100% 1 per calendar year age 40 and up
PHYSICIAN OFFICE SERVICES (Medically Necessary)					
Office Visits/ Consultations	Co-pay: \$20	Covered 80% after deductible	Co-pay: \$20	Covered 80% after deductible ⁽⁴⁾ Prior authorization may be required	Covered 80% of approved amount after deductible

Health Plans Coverage Summary (continued)

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EMERGENCY MEDICAL CARE					
Hospital Emergency Room	Co-pay: \$250 (waived based on signs and symptoms, accident or if admitted)	Co-pay: \$250 (waived based on signs and symptoms, accident or if admitted)	Co-pay: \$250 (waived based on signs and symptoms, accident or if admitted)	Co-pay: \$250 (waived based on signs and symptoms, accident or if admitted)	Co-pay: \$250 (waived based on signs and symptoms, accident or if admitted)
Emergency Room Physician's Services	Co-pay: \$20 (when medical emergency criteria not met)	Covered 80% after deductible	Covered 100%	Covered 100%	Covered 100%
Urgent Care Center	Co-pay: \$20	Covered 80% after deductible	Co-pay: \$20	Co-pay: \$20	Covered 80% after deductible
Ambulance Service	Covered 100% of the approved amount Subject to faculty deductible	Covered 100% of the approved amount	Covered 80% after deductible, ground and air	Covered 80% after deductible, ground and air	Covered 80% of approved amount after deductible
DIAGNOSTIC SERVICES					
Laboratory and Pathology Tests	Covered 100% Subject to faculty deductible	Covered 80% after deductible	Covered 100%	Covered 100%	Covered 100%
Diagnostic Tests and X-Rays	Covered 100% Subject to faculty deductible	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible Prior authorization may be required	Covered 100%
Radiation Therapy	Covered 100% Subject to faculty deductible	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible Prior authorization may be required	Covered 100%
MATERNITY SERVICES PROVIDED BY A PHYSICIAN					
Pre-Natal and Post-Natal Care	Covered 100%	Covered 80% after deductible	Covered 100%	Covered 80% after deductible ⁽⁴⁾ Prior authorization may be required	Covered 80% of approved amount after deductible
Delivery and Nursery Care	Covered 100% Subject to faculty deductible	Covered 80% after deductible	Covered 100% after deductible Prior authorization may be required	Covered 80% after deductible ⁽⁴⁾ Prior authorization may be required	Covered 100%
HOSPITAL CARE					
Semi-Private Room, General Nursing Care, Hospital Services and Supplies	Covered 100% (unlimited days) Prior authorization may be required Subject to faculty deductible	Covered 80% after deductible Prior authorization may be required	Covered 100% after deductible (unlimited days) Prior authorization required	Covered 80% after deductible ⁽⁴⁾ (unlimited days) Prior authorization required	Covered 100% (unlimited days) Prior authorization may be required
Inpatient Consultations	Covered 100% Subject to faculty deductible	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible ⁽⁴⁾	Covered 100% Prior authorization may be required
Chemotherapy	Covered 100% Subject to faculty deductible	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible Prior authorization may be required	Covered 100%

Health Plans Coverage Summary (continued)

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	In-Network	Out-of-Network	In-Network	Out-of-Network	Mixed Medicare ONLY
SURGICAL SERVICES					
Surgery and Related Surgical Services	Covered 100% Prior authorization may be required Subject to faculty deductible	Covered 80% after deductible Prior authorization may be required	Covered 100% after deductible Prior authorization may be required	Covered 80% after deductible Prior authorization may be required	Covered 100% Prior authorization may be required
Voluntary Sterilization	Covered 100% Subject to faculty deductible	Covered 80% after deductible	Covered 100% after deductible	Not covered	Covered 100%
HUMAN ORGAN TRANSPLANTS					
Such as: Liver, Heart, Lung, Pancreas, Heart-Lung, Kidney, Cornea, and Skin and Bone Marrow (subject to program guidelines)	Covered 100% Prior authorization may be required Subject to faculty deductible ⁽⁵⁾	Covered 80% after deductible Prior authorization may be required	Covered 100% after deductible Prior authorization is required	Not covered	Covered 100% Prior authorization may be required
NCI CLINICAL TRIALS					
Stage II and III Breast Cancer, Ovarian Cancer	Covered 100% Prior authorization may be required Subject to faculty deductible	Not covered Prior authorization may be required	Covered 100% after deductible Prior authorization may be required	Not covered	Covered 100%
ALTERNATIVES TO HOSPITAL CARE					
Skilled Nursing Care (must meet medical necessity guidelines for skilled care)	Covered 100% ⁽⁴⁾ in approved facilities (up to 120 days per calendar year) Prior authorization may be required Subject to faculty deductible		Covered 100% after deductible (combined in- and out-of-network benefits limited to 100 days per calendar year) Prior authorization required	Covered 80% after deductible (combined in- and out-of-network benefits limited to 100 days per calendar year) Prior authorization required	Covered 100% ⁽⁴⁾ in approved facilities (unlimited days) Prior authorization may be required
Hospice Care	Covered 100% ⁽⁴⁾ in approved facilities		Covered 100% after deductible Prior authorization required	Covered 80% after deductible Prior authorization required	Covered 100% ⁽⁴⁾ in approved facilities
Home Health Care (medically necessary)	Covered 100% ⁽⁴⁾ in approved facilities (unlimited visits) Subject to faculty deductible		Covered 100% after deductible (combined in- and out-of-network benefits limited to 60 days per calendar year)	Covered 80% after deductible (combined in- and out-of-network benefits limited to 60 days per calendar year) Prior authorization may be required	Covered 100% ⁽⁴⁾ in approved facilities
Individual Case Management	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%

The Health Plans Coverage Summary provided in this document is not a contract. It is intended as an easy-to-read summary to help you compare the various MSU health plan offerings. It describes plan features in general terms and is not a full description of coverages.

Health Plans Coverage Summary (continued)

Benefit	Community Blue		Blue Care Network		BCBSM Transition Plan ⁽³⁾
	In-Network	Out-of-Network	In-Network	Out-of-Network	Mixed Medicare ONLY
MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT (In approved facilities)					
Inpatient Mental Health/ Substance Abuse Care	Covered 100% Prior authorization may be required Subject to faculty deductible	Covered 80% after deductible Prior authorization may be required	Covered 100% after deductible Prior authorization required	Covered 80% after deductible ⁽⁴⁾ Prior authorization required	Covered 100% Subject to Blue Cross review Prior authorization may be required
Outpatient Mental Health/ Substance Abuse Care - Office Visits	Covered 100%	Covered 80% after deductible	Covered 100% Prior authorization may be required	Covered 80% after deductible ⁽⁴⁾ Prior authorization may be required	Covered 100%
Outpatient Mental Health/ Substance Abuse Care - Facility	Covered 100% Subject to faculty deductible	Covered 100%	Covered 100% Prior authorization may be required	Covered 80% after deductible ⁽⁴⁾ Prior authorization may be required	Covered 100%
OTHER SERVICES					
Allergy Testing and Therapy (includes allergy injections)	Covered 100%	Covered 80% after deductible	Covered 100% Office visit co-pay may apply to consultations	Covered 80% after deductible ⁽⁴⁾ Prior authorization may be required	Covered 80% of approved amount after deductible
Chiropractic Spinal Manipulation	Co-pay: \$20 (In- and out-of-network services have an annual combined maximum of 24 visits)	Covered 80% after deductible (in- and out-of-network services have an annual combined maximum of 24 visits)	Not covered	Not covered	Covered 80% after deductible up to 20 visits for the first 90 consecutive days, then 2 visits per month
Outpatient Diabetes Management (certified providers)	Co-pay: \$20	Not covered	Covered 100%	Not covered	Covered 100%
Osteopathic Manipulation by a Physician (D.O.)	Co-pay: \$20	Covered 80% after deductible in approved facilities	Co-pay: \$20	Not covered	Covered 80% of approved amount after deductible
Outpatient Physical, Speech, and Occupational Therapy (subject to medical criteria)	Covered 100% (in- and out-of-network services have an annual combined maximum of 60 visits)	Covered 80% after deductible (in- and out-of-network services have an annual combined maximum of 60 visits)	Co-pay: \$20 (combined in- and out-of-network benefits limited to 60 visits per calendar year) Prior authorization may be required	Covered 80% after deductible (combined in- and out-of-network benefits limited to 60 visits per calendar year) ⁽⁴⁾ Prior authorization may be required	Covered 100% Subject to Blue Cross review

Health Plans Coverage Summary (continued)

Benefit	Community Blue		Blue Care Network		BCBSM Transition Plan ⁽³⁾
	In-Network	Out-of-Network	In-Network	Out-of-Network	Mixed Medicare ONLY
Durable Medical Equipment (DME) and Medical Supplies	Covered 100% ⁽⁴⁾ of the approved amount		Covered 80%	Covered 80%	Covered 80% of approved amount after deductible
Private Duty Nursing	Covered 50% Subject to faculty deductible	Covered 50%	Not covered	Not covered	Covered 50% after deductible
Vision Exams	Not covered	Not covered	Not covered	Not covered	Not covered
DEDUCTIBLES, CO-PAYS, AND DOLLAR MAXIMUMS					
Deductibles	None for support staff Faculty/Acad Staff: \$100 per member/\$200 per family per calendar year	\$250 per member/ \$500 per family per calendar year (services where no network exists are covered at the in-network level)	\$100 per member/ \$200 per family per calendar year	\$500 per person/ \$1,000 family per calendar year	Basic coverage: None \$200 per person/\$400 per family per calendar year as noted in chart
Fixed Dollar Co-pays	As noted in chart	As noted in chart	As noted in chart	As noted in chart	As noted in chart
Percent Co-pays	As noted in chart	As noted in chart	As noted in chart	As noted in chart	As noted in chart
Co-Pay Maximum	Unlimited	\$2,000 per member/ \$4,000 per family per calendar year ⁽⁶⁾	\$3,000 per member/ \$6,000 per family per calendar year for ambulance (combined in- and out-of-network)	\$3,000 per member/ \$6,000 per family per calendar year \$3,000 per member/ \$6,000 per family per calendar year for ambulance (combined in- and out-of-network)	\$1,000 per contract per calendar year
Transplant Maximum	No maximum		No maximum	Not covered	No maximum
Dollar Maximums	Unlimited		Unlimited	Unlimited	Unlimited

1. Chemical profile, complete blood count (CBC), urinalysis, cholesterol testing, chest x-ray and EKG are payable as part of the Health Maintenance Exam. However, these services become subject to the faculty deductible when billed as medical/diagnostic.
2. Subject to faculty deductible with medical diagnosis.
3. BCBSM Transition Plan is available when there is a mix of Medicare (Part B) and non-Medicare enrolled family members.
4. You may be responsible for the difference between BCBSM's or BCN's approved amount and the provider's charge when services are rendered by a non-participating provider.
5. Skin, bone marrow, kidney and cornea transplants subject to faculty deductible.
6. Fixed dollar co-pays and percent co-pays for private duty nursing services are NOT applied toward this co-pay maximum.

Note: From time to time we may need to update the information in this guide to ensure the clearest and most accurate information is always available. If updates occur, updated versions will be maintained on the HR website at www.hr.msu.edu/openenrollment.

2011 Benefits Open Enrollment

Employee Monthly Health Plan Contributions (Pre-Tax through Payroll Deduction)

PLAN	COVERAGE TIER	FULL-TIME FACULTY ⁽¹⁾	FULL-TIME STAFF	3/4 TIME (65% - 89.9%) FACULTY ⁽¹⁾	3/4 TIME (65% - 89.9%) STAFF	1/2 TIME (50% - 64.9%) FACULTY ⁽¹⁾	1/2 TIME (50% - 64.9%) STAFF
Community Blue PPO with CVS/Caremark	Single	\$134.71	\$101.45	\$245.29	\$212.03	\$355.86	\$322.60
	2 person	\$282.88	\$213.04	\$515.13	\$445.29	\$747.37	\$677.53
	Family	\$329.99	\$248.49	\$602.93	\$521.43	\$875.86	\$794.36
Blue Care Network (BCN) with CVS/Caremark	Single	\$49.08	Paid by MSU	\$159.66	\$110.58	\$270.23	\$221.15
	2 person	\$103.07	Paid by MSU	\$335.32	\$232.25	\$567.56	\$464.49
	Family	\$120.26	Paid by MSU	\$393.20	\$272.94	\$666.13	\$545.87
Blue Cross Blue Shield of Michigan Transition ² with CVS/Caremark	2 person, 1 with Medicare	\$57.63	Paid by MSU	\$149.59	\$91.96	\$285.04	\$227.41
	Family, 1 with Medicare	\$77.47	Paid by MSU	\$157.26	\$79.79	\$360.90	\$283.43
	Family, 2 with Medicare	\$75.73	Paid by MSU	\$203.42	\$127.69	\$442.50	\$366.77

Employee Monthly Health Plan Contributions for Part-Time Employees When Hardship Guidelines are Met

PLAN	COVERAGE TIER	3/4 TIME (65% - 89.9%) FACULTY ⁽¹⁾	3/4 TIME (65%-89.9%) STAFF	1/2 TIME (50% - 64.9%) FACULTY ⁽¹⁾	1/2 TIME (50% - 64.9%) STAFF
Community Blue PPO with CVS/Caremark	Single	\$134.71	\$101.45	\$134.71	\$101.45
	2 person	\$393.05	\$323.21	\$665.98	\$596.14
Blue Care Network (BCN) with CVS/Caremark	Single	\$49.08	Paid by MSU	\$49.08	Paid by MSU
	2 person	\$213.24	\$110.17	\$486.17	\$383.10
Blue Cross Blue Shield of Michigan Transition ² with CVS/Caremark	2 person, 1 with Medicare	\$149.59	\$91.96	\$241.55	\$183.92

Part-time employees hired prior to July 1, 1998, with single or two-person coverage, may request the monthly hardship contribution for the following reasons: A) If they do not have access to other health coverage through a spouse's group plan, or B) If they are not married and do not have access to other health care coverage from another employer as an active employee or retiree. Forms are available at www.br.msu.edu/forms.htm.

Employee Monthly Health Plan Rider Contributions

PLAN	SPONSORED DEPENDENT RIDER FACULTY ⁽¹⁾	SPONSORED DEPENDENT RIDER STAFF	SPONSORED DEPENDENT RIDER WITH MEDICARE FACULTY ⁽¹⁾	SPONSORED DEPENDENT RIDER WITH MEDICARE STAFF
Community Blue PPO with CVS/Caremark	\$633.54	\$652.52	Not Applicable	Not Applicable
Blue Care Network (BCN) with CVS/Caremark	\$529.97	\$529.97	\$554.03	\$554.03
Blue Cross Blue Shield of Michigan Transition ² with CVS/Caremark	\$604.00	\$604.00	\$487.02	\$487.02

Footnotes: 1 - Refers to faculty, academic staff, and executive management (and includes 14% premium sharing when applicable). Faculty and academic staff with 9-month academic year (AY) appointments should see page 19 for their contributions charts.
2 - BCBSM Transition Plan is available when there is a mix of Medicare (Part B) and non-Medicare enrolled family members.