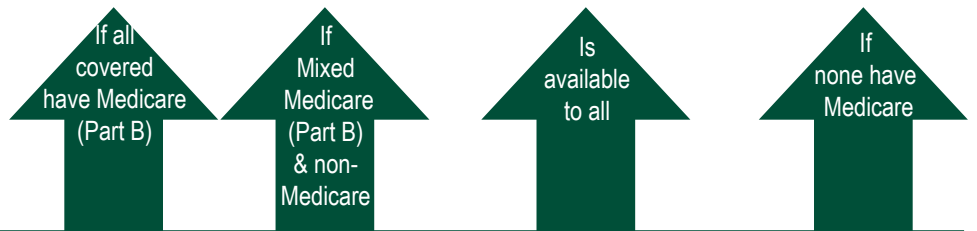


Monthly Retiree Contributions for 2011-12*

The chart below will help you determine which health plan options are available to you and the monthly rates that are associated with each plan. After determining which plans are available to you, the tables on the following pages can help you compare some basic information about the coverage offered by each plan.

Coverage Tier	BCBS Traditional	BCBS Transition	Blue Care Network (BCN)		Community Blue PPO	
			Faculty	Staff	Faculty	Staff
No Medicare (Part B)						
Retiree only (not on Medicare)	Not available	Not available	\$0	\$0	\$85.63	\$101.45
2 Person (with no Medicare)	Not available	Not available	\$0	\$0	\$179.81	\$213.04
Family (with no Medicare)	Not available	Not available	\$0	\$0	\$209.73	\$248.49
With Medicare (Part B)						
Retiree (with Medicare)	\$0	Not available	\$56.28	\$56.28	Not available	
2 Person (both with Medicare)	\$0	Not available	\$113.04	\$113.04	Not available	
Family (all with Medicare)	\$0	Not available	\$905.07	\$905.07	Not available	
Mixed - some with Medicare (Part B)						
2 Person Mixed (1 with Medicare)	Not available	\$0	\$176.25	\$176.25	Not available	
Family (1 with Medicare)	Not available	\$0	\$414.24	\$414.24	Not available	
Family (2 with Medicare)	Not available	\$0	\$658.06	\$658.06	Not available	

* Assumes full University contribution - prorated for part-time (see note below)



Note: If you need additional information about part-time retiree contribution requirements or rates for health plan riders for sponsored dependents, visit the HR website at www.hr.msu.edu, email benefitsinfo@hr.msu.edu, or call 517-353-4434 (toll-free at 1-800-353-4434).

An Important Note About Health Plans Coverage Summary

The health plan summaries provided on the following pages are not a contract. The information is intended to be an easy-to-read summary to help you compare the various MSU health plan offerings. The summaries describe plan features in general terms and do not provide a full description of coverages or conditions of coverage. 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.

More detailed brochures and coverage summaries can be viewed on the MSU Human Resources website at www.hr.msu.edu or obtained through MSU Benefits. To request this information, call 1-800-353-4434 or send an email to benefitsinfo@hr.msu.edu.

Health Plans Coverage Summary

Benefit	BCBS Traditional Plan	BCBS Transition Plan	Blue Care Network In-Network	BCBS Community Blue In-Network
PREVENTIVE SERVICES				
Health Maintenance Exam	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100% 1 per calendar year
Annual Gynecological Exam	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100% 1 per calendar year
Pap Smear Screening (lab services only)	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100% 1 per calendar year
Mammography Screening	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100% 1 per calendar year Subject to faculty deductible with medical diagnosis
Well-Baby and Child Care Exams	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%
Immunizations	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%
Flu Shots	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%
Prostate Exam	Covered - 100% 1 per calendar year age 40 and up	Covered - 100% 1 per calendar year age 40 and up	Covered - 100%	Covered - 100% 1 per calendar year age 40 and up
Fecal Occult Blood Screening	Covered - 100% 1 per calendar year	Covered - 100%	Covered - 100%	Covered - 100% 1 per calendar year
Colonoscopy	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%
Flexible Sigmoidoscopy Exam	Covered - 100% 1 per calendar year	Covered - 100% 1 per calendar year	Covered - 100%	Covered - 100% 1 per calendar year
Prostate Specific Antigen (PSA) Test	Covered - 100% 1 per calendar year age 40 and up	Covered - 100% 1 per calendar year age 40 and up	Covered - 100%	Covered - 100% 1 per calendar year age 40 and up
PHYSICIAN OFFICE SERVICES (Medically Necessary)				
Office Visits/Consultations	Covered - under Master Medical - 80% after deductible	Covered - 80% after deductible	Co-pay: \$20	Co-pay: \$20
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)

Health Plans Coverage Summary (continued)

Benefit	BCBS Traditional Plan	BCBS Transition Plan	Blue Care Network In-Network	BCBS Community Blue In-Network
Emergency Room Physician's Services	Covered - 100%	Covered - 100%	Covered - 100%	Co-pay: \$20 (when medical emergency criteria not met)
Urgent Care Center	Covered - under Master Medical - 80% after deductible	Covered - 80% after deductible	Co-pay: \$20	Co-pay: \$20
Ambulance Service	Covered - under Master Medical - 80% after deductible	Covered - 80% after deductible	Covered - 80% after deductible, ground and air	Covered - 100% of the approved amount Subject to faculty deductible
DIAGNOSTIC SERVICES				
Laboratory and Pathology Tests	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100% Subject to faculty deductible
Diagnostic Tests and X-Rays	Covered - 100%	Covered - 100%	Covered - 100% after deductible	Covered - 100% Subject to faculty deductible
Radiation Therapy	Covered - 100%	Covered - 100%	Covered - 100% after deductible	Covered - 100% Subject to faculty deductible
MATERNITY SERVICES PROVIDED BY A PHYSICIAN				
Pre-Natal and Post-Natal Care	Covered - under Master Medical - 80% after deductible	Covered - 80% after deductible	Covered - 100%	Covered - 100%
Delivery and Nursery Care	Covered - 100%	Covered - 100%	Covered - 100% after deductible Prior authorization may be required	Covered - 100% Subject to faculty deductible
HOSPITAL CARE				
Semi-Private Room, General Nursing Care, Hospital Services and Supplies	Covered - 100% up to 365 days, 60-day renewal, additional days under Master Medical at 100%, no deductible Prior authorization may be required	Covered - 100% (unlimited days) Prior authorization may be required	Covered - 100% after deductible (unlimited days) Prior authorization required	Covered - 100% (unlimited days) Prior authorization may be required Subject to faculty deductible
Inpatient Consultation	Covered - 100% Prior authorization may be required	Covered - 100% Prior authorization may be required	Covered - 100% after deductible	Covered - 100% Subject to faculty deductible
Chemotherapy	Covered - 100%	Covered - 100%	Covered - 100% after deductible	Covered - 100% Subject to faculty deductible
ALTERNATIVES TO HOSPITAL CARE				
Skilled Nursing Care (must meet medical criteria)	Covered - 100% in approved facilities (up to 730 days for general medical conditions) Prior authorization may be required	Covered - 100% in approved facilities (unlimited days) Prior authorization may be required	Covered - 100% after deductible (combined in-network and out-of-network benefits limited to 100 days per benefit period) Prior authorization required	Covered - 100% in approved facilities (up to 120 days per calendar year) Prior authorization may be required Subject to faculty deductible
Hospice Care	Covered - 100%, in approved facilities	Covered - 100%	Covered - 100% after deductible Prior authorization required	Covered - 100%, in approved facilities

Health Plans Coverage Summary (continued)

Benefit	BCBS Traditional Plan	BCBS Transition Plan	Blue Care Network In-Network	BCBS Community Blue In-Network
Home Health Care (medically necessary)	Covered - 100%	Covered - 100% In approved facilities	Covered - 100% after deductible (combined in-network and out-of-network benefits limited to 60 days per calendar year)	Covered - 100% In approved facilities (unlimited visits) Subject to faculty deductible
SURGICAL SERVICES				
Surgery and Related Surgical Services	Covered 100% Prior authorization may be required	Covered 100% Prior authorization may be required	Covered 100% after deductible Prior authorization may be required	Covered 100% Prior authorization may be required
MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT (In approved facilities)				
Inpatient Mental Health/ Substance Abuse Care	Covered - 100% Prior authorization may be required	Covered - 100% Subject to Blue Cross review Prior authorization may be required	Covered 100% after deductible Prior authorization required	Covered 100% Prior authorization may be required Subject to faculty deductible
Outpatient Mental Health Care	Covered - 80% under Master Medical after deductible	Covered - 100%	Covered 100% Prior authorization may be required	Covered - 100%
Outpatient Substance Abuse Care	Covered - 100%	Covered - 100%	Covered 100% Prior authorization may be required	Covered - 100%
OTHER SERVICES				
Allergy Testing and Therapy (includes allergy injections)	Covered under Master Medical 80% after deductible	Covered - 80% after deductible	Covered 100% Office visit co-pay may apply to consultations	Covered - 100%
Chiropractic Spinal Manipulation (must be medically necessary)	Covered under Master Medical - 80% after deductible, up to 20 visits for first 90 consecutive days, then 2 visits per month	Covered - 80% after deductible up to 20 visits for the first 90 consecutive days, then 2 visits per month	Not covered	Co-pay: \$20 (in-network and out-of-network services have an annual combined maximum of 24 visits)
Outpatient Diabetes Management Program (Certified Provider)	Covered - 100% Diabetic training	Covered - 100% Diabetic training	Covered - 100%	Co-pay: \$20
Outpatient Physical, Speech, and Occupational Therapy	Covered - 100% up to 60 consecutive days of treatment per condition, additional benefits under Master Medical at 80% after deductible	Covered - 100% Subject to Blue Cross review	Co-pay: \$20 (60 combined visits per calendar year) Prior authorization required	Covered - 100% (in- and out-of-network services have an annual combined maximum of 60 visits)

Health Plans Coverage Summary (continued)

Benefit	BCBS Traditional Plan	BCBS Transition Plan	Blue Care Network In-Network	BCBS Community Blue In-Network
Durable Medical Equipment (DME) and Medical Supplies	Covered under Master Medical - 80% after deductible	Covered - 80% after deductible	Covered - 80% Prior authorization may be required	Covered - 100%
Private Duty Nursing	Covered under Master Medical - 50% after deductible	Covered - 50% after deductible	Not covered	Covered - 50%
Vision Exams	Not covered	Not covered	Not covered	Not covered
FOREIGN TRAVEL				
Hospital Services	Covered - 100%	Covered - 100%	Covered - up to the group's level of benefits, subject to applicable co-pays if approved emergency	Covered - up to the group's level of benefits, subject to applicable co-pays
Physician Services	Basic services covered at 100%. Master Medical deductible and co-pay may apply to some physician outpatient services	Covered - 100%	Covered - up to the group's level of benefits, subject to applicable co-pays if approved emergency	Covered - up to the group's level of benefits, subject to applicable co-pays
DEDUCTIBLES, CO-PAYS, AND DOLLAR MAXIMUMS				
Deductibles	Basic coverage - none Master Medical: \$200 per member/\$400 family	Basic coverage - none Master Medical: \$200 per member/\$400 family	\$100 per member/\$200 per family per calendar year	None for support staff retirees \$100 per member/\$200 per family per calendar year for pre-65 faculty and academic staff retirees
Fixed Dollar Co-pays	As noted in chart	As noted in chart	As noted in chart	As noted in chart
Percent Co-pays	General services: none Master Medical: 20% as noted, 50% on private duty nursing, except where otherwise indicated	General services: none 20% as noted, 50% on private duty nursing, except where otherwise indicated	As noted in chart	As noted in chart 50% for private duty nursing
Co-pay Maximum	Basic coverage: none Master Medical: \$1,000 contract per calendar year	Basic coverage: none Cost sharing services: \$1,000 per contract per calendar year	\$3,000 per member/ \$6,000 per family per calendar year for out-of-network services \$3,000 per member/ \$6,000 per family per calendar year for ambulance (combined in- and out-of-network)	Unlimited \$2,000 per member/ \$4,000 per family per calendar year for out-of-network services
Dollar Maximums	Basic coverage: none except as noted above	No maximum	Unlimited	No maximum
Transplant Maximum	No maximum	No maximum	No maximum	No maximum