Health Plan Coverage Summary

Benefit	BCBSM Traditional Plan	Blue Care Network (BCN) In–Network	Humana Medicare Advantage	Humana Non-Medicare PPO In-Network
PREVENTIVE SERVICES				
Health Maintenance Exam 1 per calendar year	Covered – 100%	Covered – 100%	Covered – 100% Routine Physical Exam	Covered – 100%
Annual Gynecological Exam 1 per calendar year	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Pap Smear Screening (lab services only) 1 per calendar year	Covered – 100%	Covered – 100%	Covered – 100% Every 24 Months for Preventive	Covered – 100%
Contraceptive Devices (IUD, Diaphragm, Norplant)	Covered – 100%	Covered – 100%	Not a Preventive service[1]	Covered – 100%
Contraceptive Injections	Covered – 100%	Covered – 100%	Not a Preventive service[1]	Covered – 100%
Mammography Screening 1 per calendar year	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Well–Baby and Child Care Exams	Covered – 100%	Covered – 100%	Covered – 100% (Medicare-eligible)	Covered – 100%
Immunizations (as recommended by the Advisory Committee on Immunization Practices or mandated by the Affordable Care Act)[7]	Covered – 100%	Covered – 100%	Part B: Influenza and Pneumococcal Immunizations – Covered 100% Part D: Other immunizations (example Shingrix) are subject to co-pay through pharmacy benefit based on tier *Some immunizations require a determination to classify as Part B or Part D	Covered – 100%
Flu Shots	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Prostate Exam 1 per calendar year[2]	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Fecal Occult Blood Screening 1 per calendar year	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Preventive Colonoscopy – 1 per calendar year[2]	Covered – 100%	Covered – 100%	Covered – 100% Every 24 Months for Preventive	Covered – 100%
Flexible Sigmoidoscopy Exam 1 per calendar year	Covered – 100%	Covered – 100%	Covered – 100% Every 48 Months for Preventive	Covered – 100%
Prostate Specific Antigen Test 1 per calendar year[2]	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
PHYSICIAN OFFICE SERVICES (MEDICALLY NECESSARY)				
Office Visits/Consultations	Covered – 80% after deductible	Co–pay: $20	Covered - 96% after deductible [5]	Co–pay: $20
EMERGENCY MEDICAL CARE				
Hospital Emergency Room	Co–pay: $50 (if emergency services provided or if admitted) OR $250	Co–pay: $50 (if emergency services provided or if admitted) OR $250	Co-pay: $50 (waived if admitted within 24 hours)	Co-pay: $50 (waived if admitted during visit)
Emergency Room Physician's Services	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Urgent Care Center	Covered – 80% after deductible	Co–pay: $25	Covered - 96%	Co–pay: $25
Ambulance Service Must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible, ground and air	Covered – 96% after deductible, ground and air	Covered – 80% after deductible, ground and air

Benefit	BCBSM Traditional Plan	Blue Care Network (BCN) In-Network	Humana Medicare Advantage	Humana Non-Medicare PPO In-Network
DIAGNOSTIC SERVICES				
Laboratory and Pathology Tests	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Diagnostic Tests and X-Rays	Covered – 100%	Covered – 100% after deductible Prior authorization may be required	Covered – 96%- 100% Prior authorization may be required	Covered – 100% after deductible Prior authorization may be required
Radiation Therapy	Covered – 100%	Covered – 100% after deductible	Covered – 100% Prior authorization may be required	Covered – 100% after deductible
MATERNITY SERVICES PROVIDED BY A PHYSICIAN				
Pre-Natal and Post-Natal Care	Pre-Natal Covered – 100% Post-Natal Covered – 80% after deductible	Covered – 100%	Covered at the applicable service/place of treatment cost share	Covered – Same as Other Physician Services
Delivery and Nursery Care	Covered – 100%	Covered – 100% after deductible Prior authorization may be required	Covered at the applicable service/place of treatment cost share	Covered – 100% after deductible
HOSPITAL CARE				
Semi-Private Room, General Nursing Care, Hospital Services and Supplies	Covered – 100% (unlimited days) Prior authorization may be required	Covered – 100% after deductible (unlimited days) Prior authorization required	Covered – 100% after deductible (unlimited days) Prior authorization required	Covered – 100% after deductible (unlimited days) Prior authorization required
Inpatient Consultation	Covered – 100% Prior authorization may be required	Covered – 100% after deductible	Covered – 100%	Covered – 100% after deductible
Chemotherapy	Covered – 100%	Covered – 100% after deductible	Covered – 100% (Inpatient)[1]	Covered – 100% after deductible
ALTERNATIVES TO HOSPITAL CARE				
Skilled Nursing Care (must meet medical criteria)	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 calendar year) Prior authorization required	Covered – 100% (combined in- network and out-of-network benefits limited to 100 days per benefit period) Prior authorization required	Covered – 100% after deductible (combined in-network and out-of-network benefits limited to 100 days per calendar year) Prior authorization required
Hospice Care	Covered – 100% With approved providers	Covered – 100% after deductible Prior authorization required	Covered under Original Medicare while on the plan	Covered – 100% after deductible Prior authorization required
Home Health Care (medically necessary)	Covered – 100% With approved providers	Covered – 100% after deductible (combined in-network and out-of-network benefits limited to 60 days per calendar year)	Covered - 100% Excludes Personal Home Care	Covered – 100% after deductible (combined in-network and out-of-network benefits limited to 60 days per calendar year)
SURGICAL SERVICES				
Surgery and Related Surgical Services	Covered 100% Prior authorization may be required	Covered 100% after deductible Prior authorization may be required	Covered – 96% - 100%	Covered 100% after deductible Prior authorization may be required

Benefit	BCBSM Traditional Plan	Blue Care Network (BCN) In-Network	Humana Medicare Advantage	Humana Non-Medicare PPO In-Network
MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT (IN APPROVED FACILITIES)				
Inpatient Mental Health/ Substance Abuse Care	Covered – 100% Subject to Blue Cross review. Prior authorization may be required	Covered 100% after deductible Prior authorization required	Covered – 100% (190 day limit in a psychiatric facility) Prior authorization required	Covered 100% after deductible Prior authorization required
Outpatient Mental Health Care	Covered – 80% after deductible	Covered 100% Prior authorization may be required	Covered – 96% - 100% after deductible	Covered 100% Prior authorization may be required
Outpatient Substance Abuse Care	Covered – 80% after deductible	Covered 100% Prior authorization may be required	Covered – 96% - 100% after deductible	Covered 100% Prior authorization may be required
OTHER SERVICES				
Allergy Testing and Therapy (includes allergy injections)	Covered – 80% after deductible	Covered 100% Office visit co-pay may apply to consultations	Covered – 96% after deductible	Covered 100% Office visit co-pay may apply to consultations
Spinal and Osteopathic Manipulation	Covered – 80% after deductible, limited to a combined 38-visit maximum per member per calendar year	Co-pay: $20 (In-network only. Annual maximum of 24 visits) Prior authorization required	Covered – 96% after deductible No Visit Limit	Co-pay: $20 (Combined in-network and out-of-network benefits limited to 24 visits per calendar year)
Outpatient Diabetes Management Program (certified providers)	Covered – 100% Diabetic training	Covered – 100% Diabetic training	Covered – 100% Diabetic training	Covered – 100% Diabetic training
Outpatient Physical, Speech, and Occupational Therapy[4]	Covered – 100% (60 visits); Subsequent visits covered 80% after deductible Subject to Blue Cross review	Co-pay: $20 (in- and out-of-network services have an annual combined max. of 60 visits) Prior authorization required	Covered – 100% after deductible Prior authorization may be required No Visit Limit	Co-pay: $20 (Combined in- and out-of-network benefits limited to 60 visits per calendar year) Prior authorization required
Durable Medical Equipment and Medical Supplies (including breastfeeding equipment)	Covered – 80% after deductible	Covered – 80% Prior authorization may be required	Covered – 96%-100% after deductible Prior authorization may be required	Covered – 80% after deductible Prior authorization may be required
Private Duty Nursing	Covered – 80% after deductible	Not covered	Covered – 80% after deductible	Not covered
Autism Spectrum Disorder (applied behavioral analysis treatment – when rendered by an approved board-certified behavioral analyst – is limited through age 19)	Covered – 100% Prior authorization required	Co-pay: $20 per visit for applied behavioral analysis Prior authorization required	Covered – Covered - 96%-100% after deductible (Limited to Medicare covered services) Prior authorization may be required	Co-pay: $20 per visit for applied behavioral analysis Prior authorization required
FOREIGN TRAVEL [6]				

Foreign Travel	Covered for non–emergency and emergency care as well as accidental injuries	Only covered for emergency care and accidental injuries when traveling abroad	20% co-insurance for emergency services outside the U.S. and its territories after a $100 deductible. Benefit is limited to $250,000 each plan year or 60 consecutive days, whichever is reached first. Benefit does not apply to combined annual deductible or combined annual out-of-pocket maximim	Emergency care received while traveling outside the U.S. or taking a cruise is covered. Members will be required to pay for services received and submit a claim to Humana for reimbursement along with proof of payment and any medical information or records available from the provider. The charges will be converted to U.S. currency and reimbursed to the member under the out-of-network benefits after first applying either the $50 emergency room co-payment or the out-of-network deductible of $500 and 20% member co-insurance, depending on services received.
DEDUCTIBLES, CO–PAYS, AND DOLLAR MAXIMUMS				
Deductibles	$200 per member/$400 family per calendar year. Not all services are subject to the deductible. Refer to the type of service for benefit details	$100 per member/$200 per family per calendar year	$192 per member per calendar year. Not all services are subject to the deductible. Refer to the type of service for benefit details	$100 per member/$200 per family per calendar year
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 20% as noted	As noted in chart	As noted in chart	As noted in chart
Out–of–Pocket Maximum (includes deductible, co-insurance and co–pays, where applicable)	Basic coverage: none $1,200 per member/$1,400 per family per calendar year	$3,000 per member/ $6,000 per family per calendar year for medical services only(3)	$1,200 per member per calendar year	$3,000 per member/ $6,000 per family per calendar year for medical services only(3)
Transplant Maximum	No maximum	No maximum	No maximum	No maximum

1. Covered at the applicable service/place of treatment cost share.
2. Age limits may apply.
3. Two separate limits apply to In-Network and Out-of-Network services. Contact the provider for more info about out-of-network services.
4. Autism Spectrum Disorder services are not subject to Outpatient Physical, Speech, and Occupational Therapy visit limits.
5. Example: $100 total visit charge would cost $4 for member after deductible (when applicable).
6. Individuals living internationally are not eligible for the Humana plans.
7. Coverage for immunizations on the Humana Medicare Advantage plan is determined by whether it is a Part B or Part D, which is decided by Medicare. If the immunization is Part D, such as Shingrix, it will have a co-pay, whereas Part B immunizations such as influenza are covered at 100%. For the Humana Non-Medicare PPO plan, immunization coverage is determined by the Affordable Care Act. Immunizations at a pharmacy usually result in the lowest cost to you and the pharmacy can verify coverage or other as applicable.

This summary is not a contract. It is intended to help you compare the new MSU Humana plans to the MSU Blue Cross Blue Shield health plans. The new MSU Humana plans were designed based on the Blue Cross Blue Shield plans. Please note: Individuals that have an international permanent or mailing address are ineligible for the Humana health care plans.

The summary describes plan features in general terms, but is not a full description of coverage. Information provided in this guide may be updated periodically to ensure we provide the clearest and most accurate information. If updates occur, the updated version will be available on the HR website: **hr.msu.edu**.