

2010-2011 HEALTH PLAN SUMMARY

For the 2010-2011 Plan Year, employees of the LSU System will have five (5) health plan options from which to choose coverage. If you do not want to make changes to your health plan, do nothing - your current election will continue for 2011-2012. However, we do recommend that you review your plan options to ensure you have the coverage that best meets your needs. Below is a summary of benefits for the 2010-2011 Plan Year.

	LSU First Administered by LSU (CIGNA - Claims Administrator)	PPO Administered by OGB	HMO Plan Administered by Blue Cross & Blue Shield of LA	Medical Home HMO Plan (PCP must be in Region 9) Administered by Vantage Health Plan	CD-HSA Plan (Consumer Driven Plan with Health Savings Account) Administered by UnitedHealthcare															
Network Type	Nationwide	Statewide	Nationwide	Statewide	Nationwide															
Referral Required	No	No	No	Yes	No															
Lifetime Maximum	\$5 Million per person																			
Health Reimbursement Account (HRA)	Yes	No	No	No	No, but HSA Available															
HRA Rollover (maximum)	Up to \$8,000	No	No	No	No															
First Choice Provider	Yes	No	No	No	No															
Life Insurance Included	Yes	No	No	No	No															
Critical Illness Benefit	Yes	No	No	No	No															
Deductible	You pay \$0 for First Choice Providers and Generic Drugs No Plan copays All Employee and Dependent claims accumulate to meet the Deductible			None Does not include copays	None Does not include copays	Must meet deductible before co-insurance applies Employee - \$1,250 Employee plus one (spouse or child) - \$2,500 Family - \$3,000 Does not include copays														
		Option 1	Option 2																	
	Employee																			
	LSU pays	\$1,000	\$1,000																	
	You pay	500	1,500																	
	Total	1,500	2,500																	
	+ Spouse																			
	LSU pays	1,500	1,500																	
	You pay	750	2,250																	
	Total	2,250	3,750																	
	+ Child(ren)																			
	LSU pays	1,500	1,500																	
	You pay	750	2,250																	
	Total	2,250	3,740																	
Family																				
LSU pays	2,000	2,000																		
You pay	1,000	3,000																		
Total	\$3,000	\$5,000																		
Out of Pocket Maximum	<table border="0"> <tr> <td></td> <td><u>Opt1</u></td> <td><u>Opt 2</u></td> </tr> <tr> <td>Employee</td> <td>\$1,000</td> <td>\$1,000</td> </tr> <tr> <td>+Spouse</td> <td>1,500</td> <td>1,500</td> </tr> <tr> <td>+Child(ren)</td> <td>1,500</td> <td>1,500</td> </tr> <tr> <td>Family</td> <td>2,000</td> <td>2,000</td> </tr> </table> <p style="text-align: center;">You pay \$0 for First Choice Providers and Generic Drugs No Plan copays All Employee and Dependent claims accumulate to meet the Out of Pocket Maximum</p>		<u>Opt1</u>	<u>Opt 2</u>	Employee	\$1,000	\$1,000	+Spouse	1,500	1,500	+Child(ren)	1,500	1,500	Family	2,000	2,000	\$1000 per person	\$1000 per person/\$3000 per family	None	Employee - \$3,250; including deductible Employee plus one (spouse or child) - \$6,500; including deductible Family - \$9,000 for 3 members; \$11,000 for 4 members; \$11,900 for 5 or more due to statutory maximum; including deductible
	<u>Opt1</u>	<u>Opt 2</u>																		
Employee	\$1,000	\$1,000																		
+Spouse	1,500	1,500																		
+Child(ren)	1,500	1,500																		
Family	2,000	2,000																		
Prescription Drugs																				
Generic	\$0 for a 30-day supply	\$0 for a 30-day supply, after \$1,200 per	\$0 for a 30-day supply, after \$1,200 per	\$5 for a 30-day supply	Level 1 Generic: 31- day supply; \$10 copay															

¹After deductible is met

²Member also pays the difference between the billed amount and the fee schedule (also known as the Usual and Customary rate)

³Age and/or time restrictions apply

⁴Precertification required

		person per year	person per year		
Brand Name	If a Member chooses a brand name drug when a generic equivalent is available, the Member will be responsible for the difference between the brand name drug and the generic. If a Member chooses a brand name drug when there is no generic equivalent, the Member will be responsible for 10% of the brand name drug cost after the Deductible at In-Network pharmacies. Specialty medications are delivered by CuraScript, an Express Scripts specialty pharmacy. Members may only receive a 30-day supply at retail. Members must utilize home delivery for a 90 day supply. (administered by Express Scripts)	Member pays 50%; maximum \$50 per 30-day fill; after \$1200 per person per plan year, copay \$15 brand NOTE: Plan member who chooses brand name drug for which approved generic version is available, pays cost difference between brand name drug and generic plus 50% copy amount for brand name drug; cost difference will not apply to \$1,200 out of pocket maximum (administered by Catalyst Rx)	Member pays 50%; maximum \$50 per 30-day fill; after \$1200 per person per plan year, copay \$15 brand NOTE: Plan member who chooses brand name drug for which approved generic version is available, pays cost difference between brand name drug and generic plus 50% copy amount for brand name drug; cost difference will not apply to \$1,200 out of pocket maximum (administered by Catalyst Rx)	Preferred brand: \$25 copay per 30-day fill Non-preferred brand: \$50 copay per 30-day fill Specialty drugs: 20% co-insurance up to \$100 per Rx per 30-day fill (administered by VHP's Catalyst Rx)	Level 2 - Preferred Brand: 31-day supply; \$25 copay Level 3 - Non-preferred Brand: 31-day supply; \$50 copay Level 4 - Specialty: 31-day supply; \$50 copay Maintenance drugs: 31-day supply not subject to deductible subject to applicable co-payment levels 1 through 4 above refer to myuhc.com for Maintenance Medication List (administered by UHC's Prescription Solutions)
Drug Formulary	No	No	No	Yes	No
Home Delivery (Mail Order)	Same as above with the exception that Members may receive a 90-day supply through home delivery.	Same as above	Same as above	30-day supply for one copay 60-day supply for two copays 90-day supply for three copays	Level 1 - Generic: 90-day supply; \$10 copay Level 2 - Preferred Brand: 90-day supply; \$25 copay Level 3 - Non-preferred Brand: 90-day supply; \$50 copay Level 4 - Specialty: 90-day supply; \$50 copay Maintenance drugs: - 90-day supply - not subject to deductible - subject to applicable co-payment levels 1 through 4 above - refer to myuhc.com for Maintenance Medication List (administered by UHC's Prescription Solutions)
Employee Assistance Program (EAP)	Yes	No	No	No	No
Office Visit	First Choice: \$0 after HRA. In-Network: \$10% after Deductible. Out-of-Network: 30% of the Maximum Reimbursable Charge after Deductible + amount over the Maximum Reimbursable Charge.	In-Network: Member pays 10% of contracted rate ¹ Out-of-Network: Member pays 30% of fee schedule if Member resides in LA ² Member pays 10% of fee schedule if Member resides outside of LA ²	In-Network: \$15 PCP/\$25 Specialist (no referral required) Out-of-Network: Member pays 30% of fee schedule and has a separate \$1000 deductible regardless if member resides inside or outside of LA ²	In-Network: \$10 PCP/\$25 Specialist (referral required to all specialists) Out-of-Network: No coverage	Member pays 20% of contracted rate ¹
Wellness Benefits	All Baby/Child routine exams, Adult physical exams, and routine eye exams will be paid 100% without using HRA funds for First Choice and In-Network Providers.	In-Network: Routine Exams, Baby/Child Care - Member pays 10% of contracted rate. ¹ Adult Physical Exam -	In-Network: Adult Physical Exam, Baby/Child Care, Annual Eye Exam - \$15/\$25 copay Out-of-Network:	In-Network: Adult Physical Exam - \$10 medical home PCP office visit copay ³ Baby/Child Care - \$10 medical home PCP office	Routine Exams, Adult Physical Exam, Baby/Child Care, Annual Eye Exam - Member pays 0%, deductible does not

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	Out-of-Network wellness benefits will be paid 100% up to the Maximum Reimbursable Charge without using HRA funds. Members will be responsible for any amount over the Maximum Reimbursable Charge.	Member pays 0% of eligible expenses to \$500. ³ Annual Eye Exam - Not Covered. Out-of-Network: Member pays 30% of fee schedule if Member resides in LA ^{1,2} Member pays 10% of fee schedule if Member resides outside of LA ^{1,2}	Member pays 30% of fee schedule and has a separate \$1000 deductible regardless if member resides inside or outside of LA ²	visit copay ³ Annual Eye Exam - \$25 specialist office visit copay; one visit every 2 plan years ³ Out-of-Network: No coverage	apply ³
Hospital Services (inpatient)	First Choice: \$0 after HRA. In-Network: \$10% after Deductible. Out-of-Network: 30% of the Maximum Reimbursable Charge after Deductible + amount over the Maximum Reimbursable Charge	In-Network: Member pays 10% of contracted rate ^{1,4} Out-of-Network: Member pays 30% of fee schedule if Member resides in LA ^{1,2} Member pays 10% of fee schedule if Member resides outside of LA ^{1,2}	In-Network: \$100 per day; Maximum of \$300 per admission Out-of-Network: Member pays 30% of fee schedule and has a separate \$1000 deductible regardless if member resides inside or outside of LA ²	In-Network: \$100 per day; Maximum of \$300 per admission ⁴ Out-of-Network: No coverage	Member pays 20% of contracted rate ^{1,4}
Ambulatory Surgery	First Choice: \$0 after HRA. In-Network: \$10% after Deductible. Out-of-Network: 30% of the Maximum Reimbursable Charge after Deductible + amount over the Maximum Reimbursable Charge.	In-Network: Member pays 10% of contracted rate ¹ Out-of-Network: Member pays 30% of fee schedule if Member resides in LA ² Member pays 10% of fee schedule if Member resides outside of LA ²	In-Network: \$100 copay Out-of-Network: Member pays 30% of fee schedule and has a separate \$1000 deductible regardless if member resides inside or outside of LA ²	In-Network: Member pays \$100 copay ⁴ Out-of-Network: No coverage	Member pays 20% of contracted rate ^{1,4}
Maternity (physician)	First Choice: \$0 after HRA. In-Network: \$10% after Deductible. Out-of-Network: 30% of the Maximum Reimbursable Charge after Deductible + amount over the Maximum Reimbursable Charge	In-Network: Member pays 10% of contracted rate Out-of-Network: Member pays 30% of fee schedule if Member resides in LA Member pays 10% of fee schedule if Member resides outside of LA	In-Network: \$90 copay. Out-of-Network: Member pays 30% of fee schedule and has a separate \$1000 deductible regardless if member resides inside or outside of LA ²	In-Network: \$10 copay, first visit (no referral required). Out-of-Network: no coverage	Member pays 20% of contracted rate ¹
Mental Health and Substance Use Disorder (Inpatient)	First Choice: \$0 after HRA. In-Network: \$10% after Deductible. Out-of-Network: 30% of the Maximum Reimbursable Charge after Deductible + amount over the Maximum Reimbursable Charge.	In-Network: \$100 copay per day; \$300 maximum per admit. Out-of-Network: Member pays 30% of fee schedule if Member resides in LA ² Member pays 10% of fee schedule if Member resides outside of LA ² (administered by ValueOptions)	In-Network: \$100 copay per day; \$300 maximum per admit. Out-of-Network: Member pays 30% of fee schedule and has a separate \$1000 deductible regardless if member resides inside or outside of LA ²	In-Network: \$100 copay per day; \$300 maximum per admit. Out-of-Network: No coverage	Member pays 20% of contracted rate ^{1,4}
Mental Health and Substance Use Disorder (Outpatient)	First Choice: \$0 after HRA. In-Network: \$10% after Deductible. Out-of-Network: 30% of after Deductible + amount over the Maximum Reimbursable Charge	In-Network: \$25 office visit copay. Out-of-Network: Member pays 30% of fee schedule if Member resides in LA ^{2,4} Member pays 10% of fee schedule if Member resides outside of LA ^{2,4} (administered by ValueOptions)	In-Network: \$25 office visit copay. Out-of-Network: Member pays 30% of fee schedule and has a separate \$1000 deductible regardless if member resides inside or outside of LA ^{2,4} (administered by ValueOptions)	In-Network: 100% after \$25 copay per office visit. Out-of-Network: None (administered by Vantage Health)	Member pays 20% of contracted rate ^{1,4} (administered by Optum Health)

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Physical, Occupational and Speech Therapy	First Choice: \$0 after HRA. In-Network: \$10% after Deductible. Out-of-Network: 30% of the Maximum Reimbursable Charge after Deductible + amount over the Maximum Reimbursable Charge.	In-Network: Member pays 10% of contracted rate ¹ Out-of-Network: Member pays 30% of fee schedule if Member resides in LA Member pays 10% of fee schedule if Member resides outside of LA. *Maximum of 50 visits per plan year	In-Network: \$15 copay Out-of-Network: Member pays 30% of fee schedule and has a separate \$1000 deductible regardless if member resides inside or outside of LA ²	In-Network: 20% co-insurance; combined maximum of 20 visits per plan year ⁴ (Pre-certification only required for OT & Speech Therapy) Out-of-Network: No coverage	Member pays 20% of contracted rate ^{1,4} (Maximum of 50 visits per plan year)
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This comparison chart is a summary of plan features. For full details of the plan, refer to the official plan documents.

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