

## IN-NETWORK

Chart IA: In-Network General Coverage Comparison for All Medical Plans 1,2  
Effective January 1, 2009

	BlueEdge HSA	BCBS PPO	HMO Illinois	BCBS Traditional <sup>2</sup> (Closed to new participants)	CIGNA Choice Funds HSA (Closed after 2008)	CIGNA Network Open Access (Closed after 2008)
<b>Employer HSA Contribution</b>	\$500 single \$1,000 >single	n/a	n/a	n/a	\$500 single \$1,000 >single	n/a
<b>Lifetime Maximum</b>	Unlimited	\$3,000,000*	Unlimited	\$1,000,000 (major med)	Unlimited	Unlimited
<b>Annual Deductible</b>	\$1,200 single \$2,400 >single	\$200 / person \$400 / family	\$0	\$250 / person \$500 / family (major med) <sup>3</sup>	\$1,200 single \$2,400 >single	\$0
<b>Annual Out-of-Pocket Maximum (Deductible plus Co-insurance)</b>	\$3,000 single \$6,000 >single	\$1,200 /person \$2,400 /family	n/a	\$1,250/person \$2,500 /family	\$3,000 single \$6,000 >single	n/a
<b>PCP Required</b>	No	No	Yes	No	No	No
<b>Office Visit Co-Pay / Co-insurance (amount you pay)</b>	10%	\$20 <sup>4</sup>	\$20	20%	10%	\$20
<b>In-patient Hospital Services</b>	10%	10%	\$0	\$0 after hospital deductible <sup>3</sup> for 120 days; then, 20%	10%	\$0
<b>Rx – Retail (up to a 30-day supply)</b>	10% (Generic, Formulary, and Brand) <sup>5</sup>	30% (Generic, Formulary, and Brand) <sup>4,5</sup> ; \$10 minimum, \$75 maximum	Generic: \$10 Formulary: \$20 Brand: \$35 Self-injectable: \$50	30% (Generic, Formulary, and Brand) <sup>4,5</sup> ; \$10 minimum, \$75 maximum	10% (Generic, Formulary, and Brand)	Generic: \$10 Formulary: \$20 Brand: \$35
<b>Rx – Mail Order (up to a 90-day supply)</b>	10% (Generic, Formulary, and Brand) <sup>5</sup>	Generic: \$15 <sup>4,5</sup> Formulary: \$30 <sup>4,5</sup> Brand: \$40 <sup>4,5</sup>	Generic: \$20 Formulary: \$40 Brand: \$70 Self-injectable: \$50	Generic: \$15 <sup>4,5</sup> Formulary: \$30 <sup>4,5</sup> Brand: \$40 <sup>4,5</sup>	10% (Generic, Formulary, and Brand)	Generic: \$20 Formulary: \$40 Brand: \$70
<b>Emergency Room</b>	10%	10%	\$75 (waived if admitted)	\$0 for hospital after hospital deductible <sup>3</sup> ; 20% for doctor	10%	\$75 (waived if admitted)
<b>Mental Health / Substance Abuse Treatment</b>	In-patient: 10% up to 45 days per year.  Out-patient: 10% up to 35 visits per year.	In-patient: 10%.  Out-patient: 10% up to 20 visits per year.	Co-Payment Out-patient: \$20 per visit, up to 20 visits per year.  In-patient: Maximum 20 days per year.	In-patient: \$0 up to 45 days per year, then 20%.  Out-patient: not covered.	In-patient: 10% up to 45 days per year.  Out-patient: 10% up to 35 visits per year.	Co-Payment Out-patient: \$20 per visit, up to 35 visits per year.  In-patient: Maximum 45 days per year.

\*Combined in-and-out-of-network deductible

## IN-NETWORK

Chart IB: In-Network Preventive Care Coverage Detailed Comparison <sup>1,2</sup>

	BlueEdge HSA	BCBS PPO	HMO Illinois	BCBS Traditional (Closed to new participants)	CIGNA Choice Funds HSA (Closed after 2008)	CIGNA Network Open Access (Closed after 2008)
<b>Well Child Care <sup>6</sup></b>						
Routine Immunizations:	Yes	Yes	Yes	Yes <sup>7</sup>	Yes	Yes
Routine Physical Examinations:	Yes	Yes	Yes	Yes <sup>7</sup>	Yes	Yes
Routine Diagnostic Tests:	Yes	Yes	Yes	Yes <sup>7</sup>	Yes	Yes
Deductible:	No	No	No	No	No	No
Co-insurance (% of bill paid by you):	0%	0%	0%	0% <sup>7</sup>	0%	0%
Limits Regarding Frequency of Testing:	None	None	Yes <sup>8</sup>	None, but no benefit after age 15 <sup>7</sup>	Yes	Yes
Doctor Office Co-payment:	\$0	\$0	\$20	\$0	\$0	\$20
Annual Maximum:	None	None	None	\$100	None	None
<b>Wellness Care <sup>6</sup></b>						
Routine Immunizations:	Yes	Yes	Yes	No	Yes	Yes
Routine Physical Examinations:	Yes	Yes	Yes	No	Yes	Yes
Routine Diagnostic Tests:	Yes	Yes	Yes	No	Yes	Yes
Routine Gynecological Examinations:	Yes	Yes	Yes	No	Yes	Yes
Routine Mammograms:	Yes	Yes	Yes	Yes <sup>7</sup>	Yes	Yes
Colorectal Cancer Screening and Colonoscopies:	Yes	Yes <sup>9</sup>	Yes	No	Yes	Yes
Routine Prostate-related Testing:	Yes	Yes	Yes	Yes <sup>7</sup>	Yes	Yes
Deductible:	No	No	No	No	No	No
Co-insurance (% of bill paid by you):	0%	0%	0%	0% <sup>7</sup>	0%	0%
Limits Regarding Frequency or Type of Preventive Care Services:	None	Yes <sup>9</sup>	Yes <sup>8</sup>	Yes <sup>7</sup>	Yes	Yes
Annual Maximum:	None	None	None	n/a	None	None
Doctor Office Co-payment:	\$0	\$0	\$20	\$0	\$0	\$20

## OUT-OF-NETWORK

Chart IIA: Out-of-Network General Coverage Comparison for All Medical Plans <sup>1,2</sup>  
Effective January 1, 2009

	BlueEdge HSA	BCBS PPO	HMO Illinois	BCBS Traditional <sup>2</sup> (Closed to new participants)	CIGNA Choice Funds HSA (Closed after 2008)	CIGNA Network Open Access (Closed after 2008)
Employer HSA Contribution	\$500 single \$1,000 >single	n/a	n/a	n/a	\$500 single \$1,000 >single	n/a
Lifetime Maximum	Unlimited	\$3,000,000*	n/a	\$1,000,000 (major med)	Unlimited	n/a
Annual Deductible	\$2,400 single \$4,800 >single	\$400 / person \$800 / family	n/a	\$250 / person \$500 / family (major med) <sup>3</sup>	\$2,400 single \$4,800 >single	n/a
Annual Out-of-Pocket Maximum (Deductible plus Co-insurance)	\$6,000 single \$12,000 >single	\$2,400 /person \$4,800 /family	n/a	\$1,250/person \$2,500 /family	\$6,000 single \$12,000 >single	n/a
PCP Required	No	No	Not Covered	No	No	Not Covered
Office Visit Co-Pay / Co-insurance (amount you pay)	30%	30%	Not Covered	20%	30%	Not Covered
In-patient Hospital Services	30%	30%	Not Covered	\$0 after hospital deductible <sup>3</sup> for 120 days; then, 20%	30%	Not Covered
Rx – Retail (up to a 30-day supply)	25% (Generic, Formulary, and Brand) <sup>5</sup>	30% (Generic, Formulary, and Brand) <sup>4,5</sup> ; \$10 minimum, \$75 maximum	Not Covered	30% (Generic, Formulary, and Brand) <sup>4,5</sup> ; \$10 minimum, \$75 maximum	30% (Generic, Formulary, and Brand)	Not Covered
Rx – Mail Order (up to a 90-day supply)	Not Covered	Not Covered	Not Covered	Generic: \$15 <sup>4,5</sup> Formulary: \$30 <sup>4,5</sup> Brand: \$40 <sup>4,5</sup>	Not Covered	Not Covered
Emergency Room	10% (30% for non-emergency)	10%	\$75 (waived if admitted)	\$0 for hospital after hospital deductible <sup>3</sup> ; 20% for doctor	10% (30% for non-emergency)	\$75 (waived if admitted)
Mental Health / Substance Abuse Treatment	In-patient: 30% up to 45 days per year.  Out-patient: 30% up to 35 visits per year	In-patient: 30%.  Out-patient: 30% up to 20 visits per year	Not Covered	In-patient: \$0 up to 45 days per year, then 20%.  Out-patient: not covered.	In-patient: 30% up to 45 days per year.  Out-patient: 30% up to 35 visits per year	Not Covered

\*combined in-and-out-of network

## OUT-OF-NETWORK

Chart IIB: Out-of-Network Preventive Care Coverage Detailed Comparison <sup>1,2</sup>

	BlueEdge HSA	BCBS PPO	HMO Illinois	BCBS Traditional (Closed to new participants)	CIGNA Choice Funds HSA (Closed after 2008)	CIGNA Network Open Access (Closed after 2008)
<b>Well Child Care <sup>6</sup></b>						
Routine Immunizations:	Yes	Yes	n/a	Yes <sup>7</sup>	Yes	n/a
Routine Physical Examinations:	Yes	Yes	n/a	Yes <sup>7</sup>	Yes	n/a
Routine Diagnostic Tests:	Yes	Yes	n/a	Yes <sup>7</sup>	Yes	n/a
Deductible - see SPD for amount:	Yes	Yes	n/a	No	Yes	n/a
Co-insurance (% of bill paid by you after deductible):	30%	30%	n/a	0%	30%	n/a
Limits Regarding Frequency of Testing:	None	None	n/a	None, but no benefit after age 15 <sup>7</sup>	Yes	n/a
Annual Maximum:	None	None	n/a	\$100	None	n/a
Doctor Office Co-payment:	No	No	n/a	No	No	n/a
<b>Wellness Care <sup>6</sup></b>						
Routine Immunizations:	Yes	Yes	n/a	No	Yes	n/a
Routine Physical Examinations:	Yes	Yes	n/a	No	Yes	n/a
Routine Diagnostic Tests:	Yes	Yes	n/a	No	Yes	n/a
Routine Gynecological Examinations:	Yes	Yes	n/a	Some <sup>7</sup>	Yes	n/a
Routine Mammograms:	Yes	Yes	n/a	Yes <sup>7</sup>	Yes	n/a
Routine Colorectal Cancer Screening and Colonoscopies:	Yes	Yes <sup>9</sup>	n/a	No	Yes	n/a
Routine Prostate-related Testing:	Yes	Yes	n/a	Yes <sup>7</sup>	Yes	n/a
Deductible – see SPD for amount:	Yes	Yes	n/a	No	Yes	n/a
Co-insurance (% of bill paid by you, after deductible):	30%	30%	n/a	0%	30%	n/a
Limits Regarding Frequency or Type of Preventive Care Services:	Yes <sup>11</sup>	Yes <sup>10,11</sup>	n/a	Yes <sup>7</sup>	Yes <sup>11</sup>	n/a
Annual Maximum:	None	None	n/a	n/a	None	n/a
Doctor Office Co-payment:	\$0	\$0	n/a	\$0	\$0	n/a

n/a – benefits not available

## Footnotes

1. Unless otherwise noted, all services are subject to annual deductibles.
2. All services are subject to usual and customary charges and the deductible unless otherwise noted.
3. There is a \$150 per person annual hospital deductible.
4. Not subject to annual deductible.
5. Under the prescription drug program, the member pays the applicable coinsurance and/or copay plus the difference between the cost of the brand and generic drug if the brand drug is selected. If physician indicates dispense as written, member does not pay the difference in cost.
6. Follow-up doctor visits and tests performed as a result of a potential health problem discovered during preventive care screenings are covered as normal medical expenses rather than as preventive care. For example, a colonoscopy performed as a result of a potential problem discovered during a routine physical would not be covered as a preventive care benefit; rather, it would be covered as a normal medical procedure.
7. Only charges for services that are reasonable and customary are eligible to be considered for reimbursement by the plan. Also, plan reimbursements will be limited to the annual maximum specified in the table.
8. All services must be approved by the Primary Care Physician (PCP). For some procedures, the PCP uses published guidelines issued by nationally recognized professional medical societies such as the National Cancer Institute.
9. One routine sigmoidoscopy or colonoscopy is covered as a preventive care benefit every 5 years.
10. All expenses are treated as normal medical expenses and are subject to the standard deductible and co-insurance. Without a diagnostic reason for performing these procedures, only one routine sigmoidoscopy or colonoscopy is covered as a preventive care benefit every 5 years.
11. Only charges for services that are reasonable and customary are eligible to be considered for reimbursement by the plan.

**Note: This document summarizes the university's benefit programs and certain policies and procedures. The complete provisions of the programs and policies and procedures are found in the official plan documents or policy and procedure descriptions, the provisions of which rule in the event of any difference between the official plan documents and this document.**