

DePaul University
BlueEdge HSA Plan – 2009
Blue Cross and Blue Shield of Illinois
Group: 000130

HSA – AMOUNT FUNDED BY DEPAUL: This amount can be used to pay for eligible health expenses.	\$500 Single \$1,000 > Single	
LIFETIME COMPREHENSIVE MAJOR MEDICAL COVERAGE: Total lifetime maximum.	Unlimited	
	In-Network	Out-of-Network
DEDUCTIBLE: Per calendar year. Family deductible must be met before any family member receives benefits under the plan. In-Network and Out-of-Network deductibles cross feed each other.	\$1,200 single \$2,400 family	\$2,400 single \$4,800 family
OUT-OF-POCKET EXPENSE LIMITATION: The amount of money an individual pays toward covered medical expenses during any one calendar year. In-Network and Out-of-Network charges cross feed each other. Elective Medical Services Advisory (MSA) co-payment and charges exceeding the Schedule of Maximum Allowances (SMA) do not apply to any out-of-pocket limit. Out-of-Network payments are based on SMA. Members can be balance billed.	\$3,000 single \$6,000 family	\$6,000 single \$12,000 family
WELLNESS CARE: Includes all wellness benefits; physicals, immunizations, routine sigmoidoscopy, colonoscopy, routine x-ray and lab; routine mammograms, pap smears, prostate exams, digital rectal exams, and colorectal cancer screenings. No benefit maximum.	100%, deductible does not apply	70%
INPATIENT SERVICES		
<ul style="list-style-type: none"> ● HOSPITAL: Room allowance based on hospital's semi-private room rate. Includes pre-admission testing, home care, hospice, skilled nursing (limited to 100 days). ● INPATIENT MENTAL HEALTH/CHEMICAL DEPENDENCY: There is no separate lifetime maximum. There is a limit of 45 days per calendar year for Mental Health and Chemical Dependency combined. ● INPATIENT SERIOUS MENTAL ILLNESS**: There is no separate lifetime maximum. **As denoted in the Diagnostic and Statistical Manual published by the American Psychiatric Association. 	90%	70%
OUTPATIENT SERVICES		
<ul style="list-style-type: none"> ● HOSPITAL: Including radiation, chemotherapy, nuclear scans (MRI, CAT, PET). ● OUTPATIENT SURGERY & DIAGNOSTIC TESTS: Hospital & Physician. ● OUTPATIENT REHABILITATION: Includes Cardiac/Pulmonary (limit of 36 visits), physical therapy, occupational therapy, speech therapy, and chiropractic services (chiropractic limited to 20 sessions). Limit of 60 sessions combined for physical, occupational, speech and chiropractic therapies). ● OUTPATIENT MENTAL HEALTH/CHEMICAL DEPENDENCY: There is a combined 35 visit limit per calendar year for Mental Health and Chemical Dependency. ● OUTPATIENT SERIOUS MENTAL ILLNESS**: 35 visit limit per calendar year for Serious Mental Illness. **As denoted in the Diagnostic and Statistical Manual published by the American Psychiatric Association. 	90%	70%
PHYSICIAN MEDICAL/SURGICAL CARE: Payments are based on the Schedule of Maximum Allowance. Out-of-Network paid at Usual & Customary (U&C). <i>Includes medical and surgical care, anesthetics, durable medical equipment, etc.</i>	90%	70%
DOCTOR'S OFFICE VISITS: Includes specialist visits, medical services provided in a doctor's or specialist's office.	90%	70%
INFERTILITY: \$10,000 lifetime maximum includes infertility drugs.	90%	70%
EMERGENCY: (Hospital) Emergency Medical and Emergency Accident - Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions following the standard emergency criteria. If an inpatient admission occurs thereafter, the MSA must be contacted within two business days.	90%	90%
OTHER COVERED SERVICES: Blood and blood components; leg, arm, and neck braces; private duty nursing; Temporomandibular Joint Dysfunction (LTM \$2,500); ambulance services; surgical dressings, casts and splints; prosthetic devices. Some states do not solicit certain provider types, if no In-Network provider exists, claims will be payable at 90%.	90%	90%
PRESCRIPTION DRUGS: Benefits are available for drugs purchased from a participating pharmacy or professional provider (retail) or through the home delivery program. Benefits for retail drugs are provided for up to a maximum of a 34 consecutive day supply. Mail order provides up to a 90 day supply of maintenance drugs. The member pays the coinsurance plus the difference when a brand name drug is selected and a generic option is available. If physician indicates dispense as written, the member does not pay difference between brand and generic.	Retail: 90% after deductible; Mail Order: 90% after deductible	Retail: 75% minus co-insurance (does not apply to deductible); Mail Order: N/A
TRANSPLANT COVERAGE: Heart, heart/lung, lung, pancreas, pancreas/kidney, liver transplants in approved facilities paid as any other condition with prior MSA approval.		
MEDICAL SERVICES ADVISORY (MSA): Notification required prior to all elective admissions. Emergency and obstetric admission notification required within two working days of admittance. Pre-certification is also required for Inpatient Admission, Skilled Nursing Facilities, Private Duty Nursing, and Home Health Care. If employee elects not to notify MSA Advisor or follow advice given, hospital benefits reduced by \$500*. Benefits will then be paid as per this plan's provisions.		
PRE-EXISTING CONDITIONS WAITING PERIOD: None		
DEPENDENT ELIGIBILITY: To age 19, full-time student or a dependent based on IRS guidelines, 23.		
COORDINATION OF BENEFITS: This program coordinates benefits with other group plans.		
* Co-payments for physician office visits do not apply to any out-of-pocket expense limitations. + Deductible does not apply to out-of-pocket expense limitations.		
Note: This sheet only highlights the general program. Specific program details are contained in the Summary Plan Description (SPD). In the case of a discrepancy, the Contracts and Plan Documents will govern.		