

## 2008-2009 HEALTH PLAN SUMMARY

For the 2008-2009 Plan Year, employees of the LSU System will have four (4) 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 2008-2009. However, we do recommend that you review your plan options to ensure you have the coverage that best meets your needs. The following table reflects **your potential out-of-pocket expenses** with each plan.

	LSU First The LSU System Health Plan <i>CIGNA</i>			PPO Plan <i>Group Benefits</i>	EPO Plan <i>United Healthcare</i>	HMO Plan <i>Humana</i>
Network Type	Nationwide			Statewide	Nationwide	Statewide
Lifetime Maximum	\$5 Million per person					
Health Reimbursement Account	Up to \$2,000 per year			Not Available		
HRA Rollover Maximum HRA rollover	Up to \$8,000			Not Available		
First Choice Provider (as available)	Yes			\$1,500		
Critical Illness Direct Cash Benefit	Yes			Not Available		
Plan Year Deductible Employees and dependents (excludes PCA where applicable)		<u>Option 1</u>	<u>Option 2</u>			
	Single	\$500	\$1,500	\$500 active; \$300 retired	\$300 active and retired non-Co-Pay services	
	+Spouse	\$750	\$2,250	To a maximum of 3 per family	To a maximum of 3 per family	
	+Child(ren)	\$750	\$2,250			
	Family	\$1,000	\$3,000			
Maximum Out-of -Pocket (includes deductible)	First Choice Provider \$0			Not Available		
Maximum Out-of -Pocket (does not include deductible)	In-network	<u>Option 1</u>	<u>Option 2</u>	\$1,000 per person	N/A (see co-pays below)	\$1,000 per person with a \$3,000 maximum per family
	Single	\$1,000	\$1,000			
	+Spouse	\$1,500	\$1,500			
	+Child(ren)	\$1,500	\$1,500			
	Family	\$2,000	\$2,000			
	Out of Network	<u>Option 1</u>	<u>Option 2</u>			
	Single	\$3,000	\$4,000			
	+Spouse	\$4,500	\$6,000			
	+Child(ren)	\$4,500	\$6,000			
	Family	\$5,000	\$8,000			
Prescription Drug	In-Network	10% after Deductible (brand drug reimbursed at generic rate if available)		Member pays 50% up to \$50 max per 30 day fill; After \$1,200 per person of pharmacy out-of-pocket: generic = \$0, brand = \$15		
	Out of Network	Member reimbursed as if prescription been filled at an in-network pharmacy				
Office Visit	First Choice	100% before Deductible		Not Available		
	In-network	10% after Deductible		10% of Contracted Rate <sup>3</sup>	\$15 PCP/ \$25 Specialist	\$15 PCP /\$25 Specialist
	Out of Network	30% after Deductible		30% of Fee Schedule <sup>1</sup> 10% of Fee Schedule <sup>2</sup>	Separate \$300 deductible 30% of fee schedule <sup>1,2</sup>	\$1,000 deductible 30% of fee schedule <sup>1,2</sup>
Wellness Benefits	Baby/Child Routine exam	100% of eligible expenses		10% of Contracted Rate <sup>3</sup>	\$15 Co-pay for PCP visits <sup>3</sup>	\$15 co-pay
	Adult Physical Exam			100% eligible expenses to \$200	100% of eligible expenses to \$200	\$15 co-pay
	Routine Eye Exam			N/A	N/A	\$15 co-pay
Hospital Services (inpatient)	First Choice	100% before Deductible		Not Available		
	In-network	10% after Deductible		10% of Contracted Rate <sup>3,4</sup>	\$100 per day <sup>4</sup> Max of \$300/ admission	\$100 per day <sup>4</sup> Max of \$300/ admission
	Out of Network	30% after Deductible		30% of Fee Schedule <sup>1,3,4</sup> 10% of Fee Schedule <sup>2,3,4</sup>	Separate \$300 deductible 30% of fee schedule <sup>1,2,4</sup>	\$1,000 deductible 30% of fee schedule <sup>1,2,4</sup>
Ambulatory Surgery Facilities	First Choice	100% before Deductible		Not Available		
	In-network	10% after Deductible		10% of Contracted Rate <sup>3</sup>	\$100 Co-pay	\$100 Co-pay
	Out of Network	30% after Deductible		30% of Fee Schedule <sup>1,3</sup> 10% of Fee Schedule <sup>2,3</sup>	Separate \$300 deductible 30% of fee schedule <sup>1,2</sup>	\$1,000 deductible 30% of fee schedule <sup>1,2</sup>
Maternity (physician only)	First Choice	100% before Deductible		Not Available		
	In-network	10% after Deductible		10% of Contracted Rate <sup>3</sup>	\$90 Co-pay	\$90 Co-pay
	Out of Network	30% after Deductible		30% of Fee Schedule <sup>1,3</sup> 10% of Fee Schedule <sup>2,3</sup>	Separate \$300 deductible 30% of fee schedule <sup>1,2</sup>	\$1,000 deductible 30% of fee schedule <sup>1,2</sup>
Mental Health and Substance Abuse (inpatient) 45 days max per year	First Choice	100% before Deductible		Not Available		
	In-network	10% after Deductible		20%; separate \$200 deductible \$50 per day max \$250 <sup>4</sup>		
	Out of Network	30% after Deductible		30% of Fee Schedule and subject to additional \$200 deductible <sup>1,4</sup>		
Mental Health and Substance Abuse (outpatient) 52 days max per year	First Choice	100% before Deductible		Not Available		
	In-network	10% after Deductible		20% & subject to additional \$200 deductible <sup>4</sup>		\$25 Co-pay Substance Abuse: 30 days <sup>4</sup>
	Out of Network	30% after Deductible		30% of Fee Schedule <sup>1,4</sup> 10% of Fee Schedule <sup>2,4</sup>	Separate \$300 deductible 30% of fee schedule <sup>1,2,4</sup>	\$1,000 deductible 30% of fee schedule <sup>1,2,4</sup>
Physical and Occupational Therapy	First Choice	100% before Deductible		Not Available		
	In-network	10% after Deductible		10% <sup>3</sup>	\$15 Co-pay	\$15 Co-pay
	Out of Network	30% after Deductible		30% of Fee Schedule <sup>1,3</sup> 10% of Fee Schedule <sup>2,3</sup>	\$300 deductible 30% of fee schedule <sup>1,2</sup>	\$1,000 deductible 30% of fee schedule <sup>1,2</sup>

<sup>1</sup> Member resides in Louisiana

<sup>2</sup> Member resides outside of Louisiana

<sup>3</sup> Subject to plan year deductible

<sup>4</sup> Pre-authorization required