

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 ³ | \$15 PCP/ \$25 Specialist | \$15 PCP /\$25 Specialist |
| | Out of Network | 30% after Deductible | | 30% of Fee Schedule ¹ 10% of Fee Schedule ² | Separate \$300 deductible 30% of fee schedule ^{1,2} | \$1,000 deductible 30% of fee schedule ^{1,2} |
| Wellness Benefits | Baby/Child Routine exam | 100% of eligible expenses | | 10% of Contracted Rate ³ | \$15 Co-pay for PCP visits ³ | \$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 ^{3,4} | \$100 per day ⁴ Max of \$300/ admission | \$100 per day ⁴ Max of \$300/ admission |
| | Out of Network | 30% after Deductible | | 30% of Fee Schedule ^{1,3,4} 10% of Fee Schedule ^{2,3,4} | Separate \$300 deductible 30% of fee schedule ^{1,2,4} | \$1,000 deductible 30% of fee schedule ^{1,2,4} |
| Ambulatory Surgery Facilities | First Choice | 100% before Deductible | | Not Available | | |
| | In-network | 10% after Deductible | | 10% of Contracted Rate ³ | \$100 Co-pay | \$100 Co-pay |
| | Out of Network | 30% after Deductible | | 30% of Fee Schedule ^{1,3} 10% of Fee Schedule ^{2,3} | Separate \$300 deductible 30% of fee schedule ^{1,2} | \$1,000 deductible 30% of fee schedule ^{1,2} |
| Maternity (physician only) | First Choice | 100% before Deductible | | Not Available | | |
| | In-network | 10% after Deductible | | 10% of Contracted Rate ³ | \$90 Co-pay | \$90 Co-pay |
| | Out of Network | 30% after Deductible | | 30% of Fee Schedule ^{1,3} 10% of Fee Schedule ^{2,3} | Separate \$300 deductible 30% of fee schedule ^{1,2} | \$1,000 deductible 30% of fee schedule ^{1,2} |
| 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 ⁴ | | |
| | Out of Network | 30% after Deductible | | 30% of Fee Schedule and subject to additional \$200 deductible ^{1,4} | | |
| 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 ⁴ | | \$25 Co-pay Substance Abuse: 30 days ⁴ |
| | Out of Network | 30% after Deductible | | 30% of Fee Schedule ^{1,4} 10% of Fee Schedule ^{2,4} | Separate \$300 deductible 30% of fee schedule ^{1,2,4} | \$1,000 deductible 30% of fee schedule ^{1,2,4} |
| Physical and Occupational Therapy | First Choice | 100% before Deductible | | Not Available | | |
| | In-network | 10% after Deductible | | 10% ³ | \$15 Co-pay | \$15 Co-pay |
| | Out of Network | 30% after Deductible | | 30% of Fee Schedule ^{1,3} 10% of Fee Schedule ^{2,3} | \$300 deductible 30% of fee schedule ^{1,2} | \$1,000 deductible 30% of fee schedule ^{1,2} |

¹ Member resides in Louisiana

² Member resides outside of Louisiana

³ Subject to plan year deductible

⁴ Pre-authorization required