BALL STATE UNIVERSITY EDUCATION REDEFINED

Benefits-at-a-Glance Plan Year 2011 - 2012

HEALTH PLAN	Low Deductible PPO				High Deductible Wellness				High Deductible/HSA Qualified Plan			
Employee Cost:	**Biweekly**		**Monthly**		**Biweekly**		**Monthly**		**Biweekly**		**Monthly**	
Premium includes Health, Dental & Prescription cover.	**10 month (18 pays)**	**12 month (24 pays)**	**10 month**	**12 month**	**10 month (18 pays)**	**12 month (24 pays)**	**10 month**	**12 month**	**10 month (18 pays)**	**12 month (24 pays)**	**10 month**	**12 month**
Single	$140.39	$105.29	$252.70	$210.58	$56.03	$42.02	$100.85	$84.04	$24.55	$18.42	$44.20	$36.83
Employee & Child(ren)	$266.73	$200.05	$480.12	$400.10	$106.45	$79.84	$191.62	$159.68	$46.65	$34.99	$83.98	$69.98
Family	$364.42	$273.32	$655.96	$546.63	$145.44	$109.08	$261.79	$218.16	$63.74	$47.81	$114.73	$95.61
Annual Premium Amounts	**Single/EE & Ch/Family** $2527/$4801/$6560				**Single/EE & Ch/Family** $1008/$1916/$2618				**Single/EE & Ch/Family** $442/$840/$1147			
Deductibles	**$350** - Single/ **$875** - EE & Child, Family (per person **and** per EE & Child/Family)				**$1000** - Single/ **$2500** - EE & Child, Family (per person **and** per EE & Child/Family)				**$1725** - Single/ **$4325** - EE & Child, Family (per person **or** per EE & Child/Family)			
Out-of Pocket Maximum (OOP) ***Does Not Include Deductible** ****Includes Deductible**	**OOP is per person** **$1725* -** In Network/Endorsed Provider/Encircle Facility **$2600* -** Combination of In Network/Endorsed/Non-Endorsed Providers/Encircle/Non-Encircle Facility **$3450*** for Out of Network plus $2000 per each Out of Network inpatient admission				**OOP is per person** **$2500* -** In Network/Endorsed Provider/Encircle Facility **$3750* -** Combination of In Network/Endorsed/Non-Endorsed Providers/Encircle/Non-Encircle Facility **$6000*** for Out of Network plus $2000 per each Out of Network inpatient admission				**Single Coverage** **$2875** -** In Network/Endorsed Provider/Encircle Facility **$3450** -** Combination of In Network/Endorsed/Non-Endorsed Providers/Encircle/Non-Encircle Facility **$4025**** for Out of Network plus $2000 per each Out of Network inpatient admission ---------- **EE & Child or Family Coverage** **$5750** -** In Network/Endorsed Provider/Encircle Facility **$6900** -** Combination of In Network/Endorsed/Non-Endorsed Providers/Encircle/Non-Encircle Facility **$8050**** for Out of Network plus $2000 per each Out of Network inpatient admission			
<u>Not subject to deductible</u> **80%** In Network/Endorsed Provider/Encircle Facility **70%** In Network/ **<u>Non</u>**-Endorsed Provider/**<u>Non</u>** – Encircle Facility	• Wellness Benefits – Routine tests, immunizations and Office exams • Chronic Disease Physician Office visits • Quick Care Clinic ^ • Nurse Practitioners^^ • Diabetic, Asthma & Nutrition Training^ • Lab Charges^ (Contracted Labs) • Emergency Room for Illness/ Accident				• Wellness Benefits – Routine tests, immunizations, and Office exams • Chronic Disease Physician Office visits • Quick Care Clinic ^ • Nurse Practitioners^^ • Diabetic, Asthma & Nutrition Training^ • Lab Charges^ (Contracted Labs) • Emergency Room for Illness/ Accident				• Wellness Benefits – Routine Tests, Immunizations and Office Exams • Routine/Wellness Lab Charges^ (Contracted Labs)			
<u>Subject to deductible</u> **80%** In Network/Endorsed Provider/Encircle Facility **70%** In Network/ **<u>Non</u>**-Endorsed Provider/**<u>Non</u>** – Encircle Facility **60%** Out of Network Provider/Outpatient **50%** Out of Network/Inpatient	• Diagnostic Office Visits/ Injections for Illness & Accident • Hospital Inpatient and Outpatient/ Surgery • Mental, Nervous and Substance Abuse • Diagnostic X-rays and Labs for Routine/ Illness/ Accidents (Non-Contracted Labs) • Ambulance				• Diagnostic Office Visits/ Injections for Illness & Accident • Hospital Inpatient and Outpatient/ Surgery • Mental, Nervous and Substance Abuse • Diagnostic X-rays and Labs for Routine/ Illness/ Accidents (Non-Contracted Labs) • Ambulance				• Chronic Disease Physician Office visits • Quick Care Clinic ^ • Nurse Practitioners^^ • Diabetic, Asthma & Nutrition Training^ • Diagnostic Office Visits/ Injections for Illness & Accident • Hospital Inpatient and Outpatient/ Surgery • Mental, Nervous and Substance Abuse • Diagnostic X-rays and Labs for Routine/ Illness/ Accidents (Non-Contracted Labs) • Emergency Room for Illness/ Accident • Diagnostic Lab Charges ^(Contracted Labs) • Ambulance			

^100% Covered **^^Network Not Applicable**

Wellness Office Visits: Includes exam only; maximum benefit of $200 per visit

Contracted Labs: LabCorp (formerly PA Labs), Quest Diagnostic/LabCard and American Health Network

DENTAL Coverage	Low Deductible PPO	High Deductible Wellness	High Deductible HSA Plan
Deductible	$50 Single/ $100 EE & Child/ $100 Family	$50 Single/ $100 EE & Child/ $100 Family	$50 Single/ $100 EE & Child/ $100 Family
Maximum Benefits	$1500 per person per year; eliminated for children under age 18	$1500 per person per year; eliminated for children under age 18	$1500 per person per year; eliminated for children under age 18
Coverage:	Covers 100% of first preventive visit to $50 per person per year, balance of charge at 80% (after deductible is met)	Covers 100% of first preventive visit to $50 per person per year, balance of charge at 80% (after deductible is met)	Covers 100% of first preventive visit to $50 per person per year, balance of charge at 80% (after deductible is met)
	80% usual and customary to maximum benefit	80% usual and customary to maximum benefit	80% usual and customary to maximum benefit
Orthodontia	$500 per person per year (separate from Dental Benefit maximum)	$500 per person per year (separate from Benefit Dental maximum)	$500 per person per year (separate from Dental Benefit maximum)

Prescription Coverage	Low Deductible PPO		High Deductible Wellness		High Deductible HSA Plan	
Deductible	None		None		Included in Medical deductible; all drugs are subject to deductible except **preventive medication**	
Maximum Out of Pocket Expense	$1725 per person per year for mail order only; **retail costs do not apply to out-of-pocket maximums**		$1725 per person per year for mail order only; **retail costs do not apply to out-of-pocket maximums**		Included in Medical out of pocket maximum Effective January 1, 2012: Single - **$5,950** (including deductible) for retail prescription drug expenditures Employee + Child(ren)/Family - **$11,900** (including deductible) for retail prescription drug expenditures	
Covered: Retail	Generic Drugs	Name Brand Drugs	Generic Drugs	Name Brand Drugs	Generic Drugs	Name Brand Drugs
Non-Maintenance Drugs	80%	70%	80%	70%	80%	70%
Maintenance Drugs	80%	70%	80%	70%	80%	70%
After 3rd refill at retail pharmacy (**RRA Penalty**)	65%	55%	65%	55%	65%	55%
Covered: Mail Order	Generic Drugs	Name Brand Drugs	Generic Drugs	Name Brand Drugs	Generic Drugs	Name Brand Drugs
Maintenance Drugs only	80%	70%	80%	70%	80%	70%

Preventive Medications are medications taken by a person who has developed risk factors for a disease that has not yet become clinically apparent or to prevent the reoccurrence of a disease from which a person has recovered; our Pharmacy Benefit Manager (Medco) determines which drugs are considered preventive.

Retail Refill Allowance (RRA) Penalties do not apply toward the out of pocket maximums. The RRA Penalty will not be effective for the High Deductible HSA Plan until **January 1, 2012** at which time continued use of retail pharmacies could significantly increase the out-of-pocket maximum. **Brand/Generic Difference Penalties** do not apply toward the out of pocket maximums. If you request brand when a generic is available (and your doctor allows the substitution), **you will pay the coinsurance, plus the difference in cost** between the brand and the generic.