



**BlueCross BlueShield  
of Minnesota**

An independent licensee of the Blue Cross and Blue Shield Association

**2008 Comparison of Health Plan Benefit Options  
For  
THE UNIVERSITY OF ST. THOMAS**

**Platinum Plan**

**Gold Plan**

**Silver Plan**

**Bronze Plan**

	<b>Platinum Plan</b>	<b>Gold Plan</b>	<b>Silver Plan</b>	<b>Bronze Plan</b>
<b>Deductible</b>	None	\$200 Individual \$400 Family	\$500 Individual \$1,000 Family	\$1,000 Individual \$2,000 Family
<b>Annual Out of Pocket Maximum</b>	\$1,500 Individual \$3,000 Family	\$1,500 Individual \$3,000 Family	\$2,000 Individual \$4,000 Family	\$3,000 Individual \$6,000 Family
<b>Physician Office Visits</b> (office visits, lab, x-ray and in office surgery)	\$20.00 copay per visit; 100% thereafter.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter.		
<b>Physician services for surgery, anesthesia, obstetrics and in-hospital medical visits</b>	100% coverage.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter.		
<b>Inpatient Hospital Services</b> (room and board, lab tests, x-rays, medication and medical supplies)	No deductible, 90% coverage.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter.		
<b>Outpatient Hospital Services</b> (Lab tests, x-rays, kidney dialysis, radiation or chemotherapy, physical, speech and occupational, surgery)	100% coverage.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter.		
<b>Emergency Room Services</b>	\$40 copay; 100% coverage thereafter.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter.		
<b>Ambulance Service</b> (Medically necessary transportation to the nearest facility)	80% coverage up to the out of pocket maximum; 100% coverage.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter.		

<p><b>Routine/Preventive Care</b> (routine physical, lab, x-rays, eye exam immunizations, vaccinations, cancer screening tests, prenatal care, well-child care)</p>	<p>No deductible, 100% coverage.</p>
<p><b>Prescription Drugs</b> You pay your copay at time of purchase. The pharmacy will bill Prime Therapeutics, Inc. (PTI) for the balance.</p> <p><b>Your copay applies to a 31-day supply of medication, a vial of insulin or diabetic supplies.</b></p> <p>To see a list of formulary drugs, look on the Internet at <a href="http://www.bluecrossmn.com/public/">www.bluecrossmn.com/public/</a></p>	<ul style="list-style-type: none"> <li>• <b>Retail Pharmacy – 31 Day Supply</b> \$15.00 copay per prescription/refill for generic drugs. \$25.00 copay per prescription/refill for brand name formulary drugs. \$50.00 copay per prescription/refill for brand name non-formulary drugs.</li> <li>• <b>PrimeMail or 90 Day RX pharmacy-90 Day Supply</b></li> </ul> <p>Maintenance medications are also available through PrimeMail Pharmacy program. Your copay applies to a 90-day supply. \$30.00 co-pay per prescription/refill for generic drugs. \$50.00 copay per prescription/refill for brand name formulary drugs. \$100.00 copay per prescription/refill for brand name non-formulary drugs.</p> <p><i>Mandatory Generics - If you choose a brand name drug when the equivalent generic drug is available, you will also pay the difference in cost between the brand name and the generic drug, in addition to the applicable co-pay.</i></p> <p><i>Specialty Drug - Specialty drugs are used to treat serious chronic medical conditions such as multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. You must purchase these drugs through the Specialty Pharmacy Network..</i></p> <p><i>Eligible Over-the-Counter (OTC) drugs such as antihistamines for allergies and proton pump inhibitors for acid related stomach disorders are covered up to a 31-day supply as an alternative for similar prescription medications, subject to package limitations, at a retail Participating Pharmacy. When you choose OTC drugs you can receive it at no cost to you. OTC drugs are not available through Mail Service Pharmacy</i></p>
<p><b>Individual Lifetime Maximum</b></p>	<p><b>\$3,000,000</b></p>

**This summary is intended as a guide and explains the coverage available for eligible employees. For a complete description of these benefits, please refer to the Summary Plan Description. In the case of a discrepancy, the Blue Cross/Blue Shield Summary Plan Description shall prevail.**