AURORA UNIVERSITY
COMPARISON OF MEDICAL BENEFITS

BENEFIT CONCEPT	BLUE CROSS/BLUE SHIELD PPO	BLUEEDGE HCA	HMOI & BAHMO(BC/BS)
	The plan reimburses you for eligible expenses paid according to the PPO providers or schedule of benefits you select.	Annual Employer Contribution for Individual coverage: $750. Family coverage: $1,500.	HMO is a per-paid community health plan which emphasizes preventive medicine. Routine services are provided at HMOI & BAHMO facilities.
PRE-EXISTING CONDITION CLAUSE	Yes, Credit for prior creditable coverage	Yes, Credit for prior creditable coverage	No
LIFETIME MAXIMUM FOR ALL BENEFITS	$2,000,000	$5,000,000	Unlimited
ANNUAL DEDUCTIBLES	Individual - $500 PER PERSON Family – Maximum of 3 times individual	Individual - $1,500 PER PERSON Family – $3,000	None
MAXIMUM OUT-OF-POCKET PER BENEFIT PERIOD	Individual PPO - $2,000 Individual Non-PPO - $10,000 Family – Maximum of $5,000 for family	Individual PPO - $0 Individual Non-PPO - $1,000 Family PPO – Maximum of $0 for family Family Non-PPO – Maximum of $2,000 for family	None
MEDICAL SERVICES ADVISORY (MSA)			
Notification required prior to all elective admissions. Emergency and Obstetric Admission Notification required within 2 business days of admittance.	$1,000 Non-Compliance Penalty*	$1,000 Non-Compliance Penalty*	N/A
PHYSICIAN SERVICES			
Office Visits	80% PPO, after deductible 60% Non-PPO, after deductible	100% PPO, after deductible 80% Non-PPO, after deductible	$20 co-pay, No limit
Outpatient Diagnostic Services	100% PPO, deductible does not apply 80% Non-PPO, deductible does not apply	100% PPO, after deductible 80% Non-PPO after deductible	No charge
Outpatient Surgery	100% PPO, deductible does not apply 80% Non-PPO, deductible does not apply	100% PPO, after deductible 80% Non-PPO after deductible	No charge
Mammograms	100% PPO, deductible does not apply 80% Non-PPO, deductible does not apply	100% PPO, after deductible 80% Non-PPO after deductible	No charge
Registered Professional Physical, Occupational and Speech Therapist	80% PPO, after deductible 60% Non-PPO, after deductible Up to $5,000 per therapy per calendar year.	100% PPO, after deductible 80% Non-PPO after deductible Up to $5,000 per therapy per calendar year.	No charge, for up to 60 visits per calendar year.

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PREVENTIVE CARE			
Periodic Physical	80% PPO, after deductible 60% Non-PPO, after deductible	100% PPO, no deductible 80% Non-PPO, after dedutible Non-PPO maximum $500 per calendar year.	$20 co-pay
Well Child Care, to age 16 – includes Immunizations, physical exams, routine diagnostic services	100% PPO, deductible does not apply 80% Non-PPO, deductible does not apply	100% PPO, no deductible 80% Non-PPO, after dedutible Non-PPO maximum $500 per calendar year.	$20 co-pay/office visit
Eyeglass Exam	Covered under EyeMed Vision Benefits	Covered under EyeMed Vision Benefits	$20 co-pay at participating providers
Frames/Lenses	Covered under EyeMed Benefits	Covered under EyeMed Benefits	Pays up to $75 at participating providers every 24 months
Hearing Exam	Not covered	Not covered	$20 co-pay/office visit
HOSPITAL SERVICES			
Inpatient	80% PPO, after deductible 60% Non-PPO, after deductible	100% PPO, after deductible 80% Non-PPO after deductible	$150 to each of the first 5 days per calendar year
Outpatient Hospital Service	80% PPO, after deductible 60% Non-PPO, after deductible	100% PPO, after deductible 80% Non-PPO after deductible	No charge; No limit
Outpatient Surgery	100% PPO, deductible does not apply 80% Non-PPO, deductible does not apply	100% PPO, after deductible 80% Non-PPO after deductible	No charge; No limit
Outpatient Diagnostic	100% PPO, deductible does not apply 80% Non-PPO, deductible does not apply	100% PPO, after deductible 80% Non-PPO after deductible	No charge; No limit

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PRESCRIPTION DRUGS PPO Mail Order is 2x 34-day copay for 90 day HMO 90-day is 2x 34-day copay and can be purchased at Walgreen & Osco retail pharmacies	$15 co-pay Generic* $30 co-pay Formulary Brand* $50 co-pay Non-Formulary Brand*	$15 co-pay Generic $30 co-pay Formulary Brand $50 co-pay Non-Formulary Brand	$15 co-pay Generic $30 co-pay Formulary Brand $50 co-pay Non-Formulary Brand
MENTAL HEALTH & SUBSTANCE ABUSE REHABILITATION			
Inpatient	80% PPO / 60% Non-PPO after deductible up to maximum 30 days per calendar year*	60 PPO / 50% Non-PPO after deductible up to maximum 30 days per calendar year*	20 days per calendar year
Outpatient	80% PPO / 60% Non-PPO after deductible up to maximum 30 visits per calendar year*	60% PPO / 50% Non-PPO after deductible up to maximum 30 visits per calendar year*	20 visits per calendar year/$20 co-pay per visit
EMERGENCY ACCIDENT or EMERGENCY MEDICAL CARE	100%, PPO or Non-PPO, deductible does not apply	$75 co-pay, then 100% after deductible	$75 co-pay
SKILLED NURSING FACILITY	80% PPO, after deductible 50% Non-PPO, after deductible	100% PPO, after deductible 80% Non-PPO after deductible	No charge; custodial care not provided
HOME HEALTH SERVICES/HOSPICE	80% PPO, after deductible 60% Non-PPO, after deductible	100% PPO, after deductible 80% Non-PPO after deductible	No charge
MATERNITY			
Hospital	80% PPO, after deductible 60% Non-PPO, after deductible	100% PPO, after deductible 80% Non-PPO after deductible	$150 to each of the first 5 days per calendar year
Physician	80% PPO, after deductible 60% Non-PPO, after deductible	100% PPO, after deductible 80% Non-PPO after deductible	$20 co-pay/initial visit only
OTHER COVERED SERVICES			
Blood and blood components; leg, arm, back and neck braces; Private Duty Nursing ($1,000 per month*); ambulance services; allergy shots; oxygen and its administration; surgical dressings; casts and splints; durable medical equipment; prosthetic devices	80%, after deductible	100%, after deductible	No charge *Note: Coverage for Private Duty Nursing is limited to inpatient services*

*Copayments/Coinsurance does not apply to any out-of-pocket expense limitations.

Note: The above information is merely an outline of benefits and does not constitute a contract. See Master Policy for provisions, exclusions, and limitations. In addition to benefits stated herein, benefits for covered persons who reside outside of IL will conform to all extraterritorial requirements of those states according to the groups funding arrangement. The University retains the right to change policy at any time.

To locate a provider, order a replacement ID card or get other health and wellness information, visit the Blue Cross/Blue Shield website at www.bcbsil.com.

EFF: 01/01/08