

Benefit Rates & Coverage Chart

Effective July 1, 2009- June 30, 2010



- **PPO Medical Plan**
(includes Prescription & Vision coverage)
- **Dental & Orthodontia**
- **Supplemental & Dependent Life Insurance**



Deduction Note:

- The medical health care and dental rates are deducted on a pre-tax basis, while all other rates are post-tax.
- The contributions taken on a post-tax basis are those for Supplemental and Dependent Life, which are automatically deducted from your paycheck after taxes are taken out.

Faculty Members:

- Benefit contributions for all faculty members will be based on a 9-month period from October to June. This will occur regardless of the pay period you have selected. Although the deductions are taken over a 9-month period, your benefit coverages last all year.



OHIO
UNIVERSITY
Human Resources

PPO MEDICAL PLAN RATES

NOTE: Part-time Classified employees see page 7

Effective July 1, 2009 – June 30, 2010

Salary Bracket		# of Pays per Year		
		9 <i>(faculty)</i>	12 <i>(administrators)</i>	26 <i>(classified)</i>
B1: 0-\$32,099	Employee only	\$36.93	\$27.70	\$12.78
	Employee plus One	73.87	55.40	25.57
	Employee & Family	110.80	83.10	38.35
B2: \$32,100- \$37,899	Employee only	\$40.52	\$30.39	\$14.03
	Employee plus One	81.04	60.78	28.05
	Employee & Family	129.56	97.17	44.85
B3: \$37,900- \$42,199	Employee only	\$44.11	\$33.08	15.27
	Employee plus One	88.23	66.17	30.54
	Employee & Family	132.33	99.25	45.81
B4: \$42,200- \$47,999	Employee only	\$47.71	\$35.78	\$16.51
	Employee plus One	95.40	71.55	33.02
	Employee & Family	143.11	107.33	49.54
B5: \$48,000- \$53,999	Employee only	\$51.29	\$38.47	\$17.76
	Employee plus One	102.59	76.94	35.51
	Employee & Family	153.88	115.41	53.27
B6: \$54,000- \$61,799	Employee only	\$54.88	\$41.16	\$19.00
	Employee plus One	109.77	82.33	38.00
	Employee & Family	164.65	123.49	57.00
B7: \$61,800- \$71,099	Employee only	\$58.48	\$43.86	\$20.24
	Employee plus One	116.95	87.71	40.48
	Employee & Family	175.43	131.57	60.72
B8: \$71,100- \$88,699	Employee only	\$62.07	\$46.55	\$21.48
	Employee plus One	124.13	93.10	42.97
	Employee & Family	186.20	139.65	64.45
B9: \$88,700+	Employee only	\$65.65	\$49.24	\$22.73
	Employee plus One	131.31	98.48	45.45
	Employee & Family	196.97	147.73	68.18

DENTAL & ORTHODONTIA

OU Dental	# of Pays per Year		
	9 <i>(faculty)</i>	12 <i>(administrators)</i>	26 <i>(classified)</i>
Employee only*	\$0.00	\$0.00	\$0.00
Employee plus One	34.67	26.00	12.00
Employee & Family	52.00	39.00	18.00
OU Dental & Orthodontia			
Employee Orthodontia	\$13.57	\$10.18	\$4.70
Employee plus One Dental & Orthodontia	61.80	46.35	21.39
Employee & Family Dental & Orthodontia	92.71	69.53	32.09

*Please note: There is no charge for employee dental coverage.

LIFE INSURANCE

Life insurance is provided for full-time employees at a rate equal to 2.5 times the annual base salary level, to a maximum benefit of \$50,000. Employees may also purchase up to \$500,000 of additional life insurance for themselves and up to \$20,000 of life insurance for their dependents at low group rates. Accelerated life insurance, which allows employees to access up to one-half of their life insurance if they are deemed to be terminally ill, is included in the life insurance plans.

Supplemental

(Rate quoted below is per \$10,000 unit)

AGE	# of Pays per Year		
	9 (Faculty)	12 (Administrators)	26 (Classified)
Under 30	.67	.50	.23
30-34	.80	.60	.28
35-39	1.07	.80	.37
40-44	1.43	1.07	.49
45-49	2.07	1.55	.72
50-54	3.67	2.75	1.27
55-59	5.95	4.46	2.06
60-64	10.24	7.68	3.54
65-69	15.33	11.50	5.31
70-74	27.60	20.70	9.55
75+	55.60	41.70	19.25

Dependent

Coverage	9 (Faculty)	12 (Administrators)	26 (Classified)
Spouse \$5,000 Child \$2,000* <i>Option B</i>	\$1.83	\$1.37	\$.63
Spouse 10,000 Child \$5,000* <i>Option A</i>	\$3.70	\$2.78	\$1.28
Spouse \$20,000 Child \$10,000* <i>Option C</i>	\$7.41	\$5.56	\$2.56

* No coverage available birth – 14 days; \$500 coverage 15 days – 6 months; Coverage extended to age 23 if a full time student.

LONG TERM DISABILITY

Long-term disability insurance is provided for the employee and is available if an employee becomes totally disabled due to injury or disease. The benefit provides income equal to 60% of the employee's monthly earnings to a maximum of \$6,000 per month, minus other income benefits such as Social Security or those provided by the State Teachers Retirement System or Ohio's Public Employees Retirement System.

PPO COVERAGE CHART *(Frequently Utilized Categories)*

July 1, 2009- June 30, 2010

CATEGORY	TIER 1 (In-Network)	TIER 2 (Out- of-Network)
Deductible	\$200/\$400	\$400/\$800
Plan Co-Insurance	90% for most categories	70% for most categories
Employee Co-Insurance	10% for most categories	30% for most categories
Employee Plan year Out-Of-Pocket Maximum (Equal total employee co-insurance for plan year. Does not include deductible, co-pays, services or employee contributions.)	\$1000/\$2000 Individual/Family	\$1500/\$3000 Individual/Family
	Employee out-of-pocket maximums accumulate separately; therefore, charges for out-of-network services cannot be applied to the in-network employee out-of-pocket maximum and vice versa	
Individual Lifetime Maximum Benefits	\$3,000,000	
Pre-Existing Condition Limitations	None	None
Office Visit (Primary Care, Specialty Care, Physical Therapy, etc.)	No deductible - \$20 co-pay	Subject to deductible - 70% reimbursement
Inpatient & Outpatient Services, Surgery (non-emergency lab, x-ray, diagnostic testing and preadmission testing, allergy injections, serums, medically necessary colonoscopies, etc.)	Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement
Emergencies A medical emergency is defined by insurance company standards. May include a condition that if untreated could be life threatening or seriously impair bodily functions.	\$50 co-pay The employee may also be charged the deductible and co-insurance for any care received during the emergency room visit.	Paid as in-network
Preventive Care Anthem Blue Cross and Blue Shield Standards	No deductible \$20 co-pay for office visit 100% reimbursement for eligible procedures	No deductible - 70% reimbursement
Mental Health Inpatient Pre-certification required Outpatient Counseling Pre-certification required	Subject to deductible - 90% reimbursement First 5 visits of plan year No deductible EAP/Impact Provider - 100% reimbursement After 5 visits No deductible - \$20 co-pay	Subject to deductible - 70% reimbursement Non Anthem Network Provider Subject to deductible - 70% reimbursement
Prescription Plan (formulary list maintained and controlled by prescription benefits management company (PBM) and is subject to changes as directed by PBM)	Retail Co-pays: <i>Administered by Express Scripts</i> Generic Drug \$10 Brand Name Formulary \$20 Brand Name Non-Formulary \$30	Mail Order Co-pays: <i>Administered by Express Scripts</i> Generic Drug \$15 Brand Name Formulary \$30 Brand Name Non-Formulary \$45
	Generics Preferred Program and Exclusive Home Delivery Program Required	

PPO COVERAGE CHART *(Alphabetical Listing)*

July 1, 2009- June 30, 2010

CATEGORY	TIER 1 (In-Network)	TIER 2 (Out- of-Network)
Ambulance (subject to medical necessity)	Subject to deductible - 80% reimbursement	Paid as in-network
Child Health Supervision (see plan document for age intervals and dollar maximums) Total plan benefits of \$2,400 from birth up to age 2 years. \$900 for ages 2 up to age 9.	Subject to deductible \$20 co-pay for office visit 100% reimbursement for other procedures up to dollar maximums at each age interval	Subject to deductible - 70% reimbursement
Chiropractic Services	<i>Subject to medical review after 12 visits</i>	
	\$20 co-pay	Subject to deductible - 70% reimbursement
Durable Medical Equipment	Subject to deductible - 80% reimbursement	Paid as in-network
Emergencies A medical emergency is defined by insurance company standards. May include a condition that if untreated could be life threatening or seriously impair bodily functions.	\$50 co-pay The employee may also be charged the deductible and co-insurance for any care received during the emergency room visit.	Paid as in-network
Extended Care Facility Services/Skilled Nursing Facility Pre-certification and prior hospitalization required. <i>Large case management available</i>	Subject to deductible - 80% reimbursement	Paid as in-network
Gynecological Exams/PAP Smears Preventive and Diagnostic	\$20 co-pay for office visit	No deductible - 70% reimbursement.
Hearing	Subject to deductible \$40 for hearing exam and \$600 for services/equipment every 36 months	Paid as in-network
Home Health Care Services Annual maximum applies to total number of home health services. In Lieu of Hospitalization	Subject to deductible - 80% reimbursement	Paid as in-network
	Subject to deductible - 100% reimbursement	Paid as in-network
Hospice Services Pre-certification required In Lieu of Hospitalization	Subject to deductible - 80% reimbursement	Paid as in-network
	Subject to deductible - 100% reimbursement	Paid as in-network
Hospital Services	Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement
Inpatient & Outpatient Services, Surgery (non-emergency lab, x-ray, diagnostic testing and preadmission testing, allergy injections, serums, medically necessary colonoscopies, etc.)	Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement
Life Insurance	2.5 times annual pay to a maximum of \$50,000 Supplemental and Dependent Life available	
Mammograms Preventive and Diagnostic	No deductible - 100% reimbursement	No deductible - 100% reimbursement
Maternity Pre and postnatal physician services Delivery: Vaginal & Cesarean Labs & Radiology	\$20 co-pay for first visit; afterwards 90% reimbursement Subject to deductible - 90% reimbursement Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement Subject to deductible - 70% reimbursement Subject to deductible - 70% reimbursement
Mental Health Inpatient Pre-certification required Outpatient Counseling Pre-certification required	Subject to deductible - 90% reimbursement First 5 visits of plan year No deductible EAP/Impact Provider - 100% reimbursement After 5 visits No deductible - \$20 co-pay	Subject to deductible - 70% reimbursement Non Anthem Network Provider Subject to deductible - 70% reimbursement

CATEGORY <i>(Alphabetical Listing)</i>	TIER 1 (In-Network)	TIER 2 (Out- of-Network)
Office Visit (Primary Care, Specialty Care, Physical Therapy, etc.)	No deductible - \$20 co-pay	Subject to deductible - 70% reimbursement
Outpatient & Inpatient Services, Surgery (non-emergency lab, x-ray, diagnostic testing and preadmission testing, allergy injections, serums, medically necessary colonoscopies, etc.)	Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement
Physical & Occupational Therapy	<i>Subject to medical review after 40 visits</i>	
Inpatient	Subject to deductible -90% reimbursement	Subject to deductible - 70% reimbursement
Outpatient	\$20 co-pay	Subject to deductible - 70% reimbursement
Prescription Plan (formulary list maintained and controlled by prescription benefits management company (PBM) and is subject to changes as directed by PBM)	Retail Co-pays: <i>Administered by Express Scripts</i> Generic Drug \$10 Brand Name Formulary \$20 Brand Name Non-Formulary \$30	Mail Order Co-pays: <i>Administered by Express Scripts</i> Generic Drug \$15 Brand Name Formulary \$30 Brand Name Non-Formulary \$45
	Generics Preferred Program and Exclusive Home Delivery Program Required	
Preventive Care Anthem Blue Cross and Blue Shield Standards	No deductible \$20 co-pay for office visit 100% reimbursement for eligible procedures	No deductible - 70% reimbursement
Second Surgical Opinion	Subject to deductible - 100% reimbursement	Paid as in-network
Speech Therapy	<i>Subject to medical review after 20 visits</i>	
Inpatient	Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement
Outpatient	\$20 co-pay	Subject to deductible - 70% reimbursement
Substance Abuse		
Inpatient Pre-certification required	Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement
Outpatient Counseling Pre-certification required	First 5 visits of plan year No deductible EAP/Impact Provider - 100% reimbursement After 5 visits No deductible - \$20 co-pay	Non Anthem Network Provider Subject to deductible - 70% reimbursement
Surgery (inpatient, outpatient, doctor's office & other) Pre-certification required	Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement
TMJ	Subject to deductible - 80% reimbursement \$1,500 lifetime maximum for non-surgical TMJ covered services.	Paid as in-network
Transplants (Transplant program is available)	Subject to deductible - 80% reimbursement No specific maximums	Paid as in-network
Urgent Care Facility	\$20 co-pay	Subject to deductible -70% reimbursement

VISION (included with medical coverage)

<p>CLASSIFIED STAFF: Vision is currently administered by Vision Service Plan (VSP). The administrator is subject to change. VSP pays for 1 exam, lenses or contact lenses, and frames every 24 months for adults and 12 months for a dependent child. The reimbursement level for benefits depends on VSP's agreement with the provider. Call VSP directly at: 1-800-877-7195 for further details.</p>
<p>FACULTY & ADMINISTRATORS: Exam: plan pays \$25 for an exam every 12 months The plan pays for one of the following every 24 months for adults and every 12 months for children: Single Vision Lenses (with frames) \$45 Bifocals (with frames) \$55 Trifocals (with frames) \$75 Contact Lenses \$45 Medically Necessary Contact Lenses \$150</p>

DENTAL (Optional employee paid benefit)

Employee Dental (Free for full-time employees)	\$25 deductible 80% co-insurance \$750 annual maximum
Dependent Dental (Optional employee paid benefit)	Benefit per covered person: \$25 deductible 80% co-insurance \$750 annual maximum
Orthodontia (optional employee paid benefit)	Benefit per covered person: No deductible 50% co-insurance \$1,000 lifetime maximum

PART-TIME RATES FOR CLASSIFIED EMPLOYEES

Benefit rates for part-time classified employees are based on the hours worked per pay period. Rates will be deducted each pay period and are based on the B1 salary bracket: 0-\$31,600

PPO MEDICAL PLAN

<i>Hours Worked per pay period</i>	0-19 hrs/pay	20-39 hrs/pay	40-59 hrs/pay	60+ hrs/pay
Employee only	\$165.76	\$103.60	\$51.80	\$14.01
Employee plus One	331.52	207.20	103.60	28.02
Employee & Family	497.29	310.80	155.40	42.03

DENTAL PLANS

Part-time employees are eligible to purchase dental coverage for themselves and their dependents. However, employee dental must be purchased in order to cover dependents.

OU Dental

<i>Hours Worked per pay period</i>	0-19 hrs/pay	20-39 hrs/pay	40-59 hrs/pay	60+ hrs/pay
Employee only	\$9.60	\$7.20	\$4.80	\$2.40
Employee & spouse	21.60	19.20	16.80	14.40
Employee & one dependent child	21.60	19.20	16.80	14.40
Employee & more than one dependent	27.60	25.20	22.80	20.40

OU Dental & Orthodontia

<i>Hours Worked per pay period</i>	0-19 hrs/pay	20-39 hrs/pay	40-59 hrs/pay	60+hrs/pay
Employee Dental & Orthodontia	\$14.30	\$11.90	\$9.50	\$7.10
Employee plus One Dental & Orthodontia	30.99	28.59	26.19	23.79
Employee & Family Dental & Orthodontia	41.69	39.29	36.89	34.49

LIFE INSURANCE

Part-time employees must purchase Basic Life Insurance to be eligible to purchase supplemental and/or dependent life.

<i>Hours Worked per pay period</i>	0-19 hrs/pay	20-39 hrs/pay	40-59 hrs/pay	60+hrs/pay
Basic Life	\$ 3.88	\$ 2.91	\$ 1.94	\$ 0.97

OHIO UNIVERSITY

IMPORTANT BENEFIT NUMBERS



- Medical** 1-800-599-6903
- Dental** 1-866-470-7250
- Pre-cert** 1-866-776-4793
- Nurseline** 1-888-249-3820 (24 Hours)

Retail Prescription/ Mail Order Prescription



www.express-scripts.com
1-866-515-1442

Employee Assistance/ Work Life Program



www.impactemployeeassistance.com
1-800-227-6007 (24 Hours)

Flexible Spending

