

# 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

<b>Salary Bracket</b>		<b># of Pays per Year</b>		
		<b>9</b> <i>(faculty)</i>	<b>12</b> <i>(administrators)</i>	<b>26</b> <i>(classified)</i>
<b>B1: 0-\$32,099</b>	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
<b>B2: \$32,100- \$37,899</b>	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
<b>B3: \$37,900- \$42,199</b>	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
<b>B4: \$42,200- \$47,999</b>	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
<b>B5: \$48,000- \$53,999</b>	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
<b>B6: \$54,000- \$61,799</b>	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
<b>B7: \$61,800- \$71,099</b>	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
<b>B8: \$71,100- \$88,699</b>	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
<b>B9: \$88,700+</b>	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

<b>OU Dental</b>	<b># of Pays per Year</b>		
	<b>9</b> <i>(faculty)</i>	<b>12</b> <i>(administrators)</i>	<b>26</b> <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
<b>OU Dental &amp; Orthodontia</b>			
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

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**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)
<b>Under 30</b>	.67	.50	.23
<b>30-34</b>	.80	.60	.28
<b>35-39</b>	1.07	.80	.37
<b>40-44</b>	1.43	1.07	.49
<b>45-49</b>	2.07	1.55	.72
<b>50-54</b>	3.67	2.75	1.27
<b>55-59</b>	5.95	4.46	2.06
<b>60-64</b>	10.24	7.68	3.54
<b>65-69</b>	15.33	11.50	5.31
<b>70-74</b>	27.60	20.70	9.55
<b>75+</b>	55.60	41.70	19.25

## Dependent

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

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**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)
<b>Deductible</b>	\$200/\$400	\$400/\$800
<b>Plan Co-Insurance</b>	90% for most categories	70% for most categories
<b>Employee Co-Insurance</b>	10% for most categories	30% for most categories
<b>Employee Plan year Out-Of-Pocket Maximum</b> (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	
<b>Individual Lifetime Maximum Benefits</b>	\$3,000,000	
<b>Pre-Existing Condition Limitations</b>	None	None
<b>Office Visit</b> (Primary Care, Specialty Care, Physical Therapy, etc.)	No deductible - \$20 co-pay	Subject to deductible - 70% reimbursement
<b>Inpatient &amp; Outpatient Services, Surgery</b> (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
<b>Emergencies</b> 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
<b>Preventive Care</b> Anthem Blue Cross and Blue Shield Standards	No deductible \$20 co-pay for office visit 100% reimbursement for eligible procedures	No deductible - 70% reimbursement
<b>Mental Health</b> <b>Inpatient</b> Pre-certification required  <b>Outpatient Counseling</b> Pre-certification required	Subject to deductible - 90% reimbursement  <b>First 5 visits of plan year</b> 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
<b>Prescription Plan</b> (formulary list maintained and controlled by prescription benefits management company (PBM) and is subject to changes as directed by PBM)	<b>Retail Co-pays:</b> <i>Administered by Express Scripts</i> Generic Drug \$10 Brand Name Formulary \$20 Brand Name Non-Formulary \$30	<b>Mail Order Co-pays:</b> <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)
<b>Ambulance</b> (subject to medical necessity)	Subject to deductible - 80% reimbursement	Paid as in-network
<b>Child Health Supervision</b> (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
<b>Chiropractic Services</b>	<i>Subject to medical review after 12 visits</i>	
	\$20 co-pay	Subject to deductible - 70% reimbursement
<b>Durable Medical Equipment</b>	Subject to deductible - 80% reimbursement	Paid as in-network
<b>Emergencies</b> 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
<b>Extended Care Facility Services/Skilled Nursing Facility</b> Pre-certification and prior hospitalization required. <i>Large case management available</i>	Subject to deductible - 80% reimbursement	Paid as in-network
<b>Gynecological Exams/PAP Smears</b> Preventive and Diagnostic	\$20 co-pay for office visit	No deductible - 70% reimbursement.
<b>Hearing</b>	Subject to deductible \$40 for hearing exam and \$600 for services/equipment every 36 months	Paid as in-network
<b>Home Health Care Services</b> Annual maximum applies to total number of home health services. In Lieu of Hospitalization	Subject to deductible - 80% reimbursement  Subject to deductible - 100% reimbursement	Paid as in-network  Paid as in-network
<b>Hospice Services</b> Pre-certification required In Lieu of Hospitalization	Subject to deductible - 80% reimbursement  Subject to deductible - 100% reimbursement	Paid as in-network  Paid as in-network
<b>Hospital Services</b>	Subject to deductible - 90% reimbursement	Subject to deductible - 70% reimbursement
<b>Inpatient &amp; Outpatient Services, Surgery</b> (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
<b>Life Insurance</b>	2.5 times annual pay to a maximum of \$50,000 Supplemental and Dependent Life available	
<b>Mammograms</b> Preventive and Diagnostic	No deductible - 100% reimbursement	No deductible - 70% reimbursement
<b>Maternity</b>  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
<b>Mental Health</b> <b>Inpatient</b> Pre-certification required  <b>Outpatient Counseling</b> Pre-certification required	Subject to deductible - 90% reimbursement  <b>First 5 visits of plan year</b> 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

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

### VISION (included with medical coverage)

<b>CLASSIFIED STAFF:</b> 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.
<b>FACULTY &amp; ADMINISTRATORS:</b> 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

### DENTAL (Optional employee paid benefit)

<b>Employee Dental</b> (Free for full-time employees)	\$25 deductible 80% co-insurance \$750 annual maximum
<b>Dependent Dental</b> (Optional employee paid benefit)	Benefit per covered person: \$25 deductible 80% co-insurance \$750 annual maximum
<b>Orthodontia</b> (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>	<b>0-19 hrs/pay</b>	<b>20-39 hrs/pay</b>	<b>40-59 hrs/pay</b>	<b>60+ hrs/pay</b>
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>	<b>0-19 hrs/pay</b>	<b>20-39 hrs/pay</b>	<b>40-59 hrs/pay</b>	<b>60+ hrs/pay</b>
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>	<b>0-19 hrs/pay</b>	<b>20-39 hrs/pay</b>	<b>40-59 hrs/pay</b>	<b>60+hrs/pay</b>
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>	<b>0-19 hrs/pay</b>	<b>20-39 hrs/pay</b>	<b>40-59 hrs/pay</b>	<b>60+hrs/pay</b>
<b>Basic Life</b>	\$ 3.88	\$ 2.91	\$ 1.94	\$ 0.97

# OHIO UNIVERSITY

## IMPORTANT BENEFIT NUMBERS

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[www.anthem.com](http://www.anthem.com)

- 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](http://www.express-scripts.com)

1-866-515-1442

### **Employee Assistance/ Work Life Program**



[www.impactemployeeassistance.com](http://www.impactemployeeassistance.com)

1-800-227-6007 (24 Hours)

### **Flexible Spending**



[www.wageworks.com](http://www.wageworks.com)

1-877-924-3967