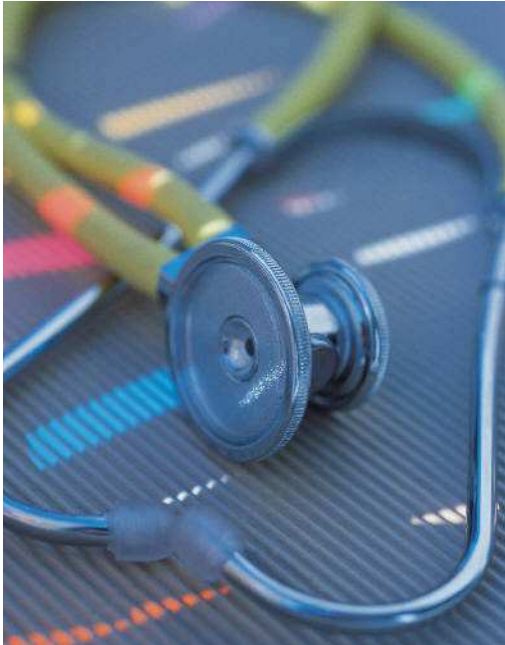


Benefit Rates & Coverage Chart

Effective July 1, 2011- June 30, 2012



- **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, 2011 – June 30, 2012

Salary Bracket	# of Pays per Year			
	9 <i>(faculty)</i>	12 <i>(administrators)</i>	26 <i>(classified)</i>	
B1 \$0 \$33,500	Employee Only	\$74.26	\$55.69	\$25.70
	Employee plus One	\$145.45	\$109.08	\$50.35
	Employee & Family	\$216.77	\$162.58	\$75.04
B2 \$33,501 \$39,300	Employee Only	\$81.48	\$61.11	\$28.20
	Employee plus One	\$159.59	\$119.69	\$55.24
	Employee & Family	\$237.85	\$178.39	\$82.33
B3 \$39,301 \$44,300	Employee Only	\$88.70	\$66.52	\$30.70
	Employee plus One	\$173.73	\$130.30	\$60.14
	Employee & Family	\$258.92	\$194.19	\$89.63
B4 \$44,301 \$50,600	Employee Only	\$95.92	\$71.94	\$33.20
	Employee plus One	\$187.87	\$140.90	\$65.03
	Employee & Family	\$280.00	\$210.00	\$96.92
B5 \$50,601 \$57,300	Employee Only	\$103.14	\$77.35	\$35.70
	Employee plus One	\$202.01	\$151.51	\$69.93
	Employee & Family	\$301.07	\$225.81	\$104.22
B6 \$57,301 \$65,100	Employee Only	\$110.36	\$82.77	\$38.20
	Employee plus One	\$216.15	\$162.11	\$74.82
	Employee & Family	\$322.15	\$241.61	\$111.51
B7 \$65,101 \$75,200	Employee Only	\$117.58	\$88.18	\$40.70
	Employee plus One	\$230.29	\$172.72	\$79.72
	Employee & Family	\$343.23	\$257.42	\$118.81
B8 \$75,201 \$93,700	Employee Only	\$124.80	\$93.60	\$43.20
	Employee plus One	\$244.43	\$183.32	\$84.61
	Employee & Family	\$364.30	\$273.23	\$126.10
B9 \$93,701 +	Employee Only	\$132.02	\$99.01	\$45.70
	Employee plus One	\$258.57	\$193.93	\$89.51
	Employee & Family	\$385.38	\$289.03	\$133.40

DENTAL & ORTHODONTIA

	# of Pays per Year		
	9 <i>(faculty)</i>	12 <i>(administrators)</i>	26 <i>(classified)</i>
OU Dental			
Employee only*	\$0.00	\$0.00	\$0.00
Employee plus One	30.67	23.00	10.62
Employee & Family	60.00	45.00	20.77
OU Dental & Orthodontia			
Employee Orthodontia	\$2.67	\$2.00	\$0.92
Employee plus One Dental & Orthodontia	36.00	27.00	12.46
Employee & Family Dental & Orthodontia	68.00	51.00	23.54

*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 34	.53	.40	.18
35-39	.80	.60	.28
40-44	.93	.70	.32
45-49	1.47	1.10	.51
50-54	2.53	1.90	.88
55-59	4.13	3.10	1.43
60-64	7.20	5.40	2.49
65-69	10.80	8.10	3.74
70-74	19.33	14.50	6.69
75+	27.47	20.60	9.51

Dependent

Coverage	9 (Faculty)	12 (Administrators)	26 (Classified)
Spouse \$5,000 Child \$2,000* <i>Option B</i>	1.61	1.21	.56
Spouse 10,000 Child \$5,000* <i>Option A</i>	3.47	2.6	1.20
Spouse \$20,000 Child \$10,000* <i>Option C</i>	6.57	4.93	2.28

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, 2011- June 30, 2012

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	Paid as in-network
	The employee may also be charged the deductible and co-insurance for any care received during the emergency room visit.	
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	Subject to deductible - 70% reimbursement
	First 6 visits of plan year No deductible EAP/Impact Provider - 100% reimbursement After 6 visits No deductible - \$20 co-pay	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, 2011- June 30, 2012

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 Subject to deductible - 100% reimbursement	Paid as in-network Paid as in-network
Hospice Services 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
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 - 70% 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 6 visits of plan year No deductible EAP/Impact Provider - 100% reimbursement After 6 visits No deductible - \$20 co-pay	Subject to deductible - 70% reimbursement Non Anthem Network Provider Subject to deductible - 70% reimbursement

CATEGORY (Alphabetical Listing)	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 Inpatient Outpatient	<i>Subject to medical review after 40 visits</i>	
	Subject to deductible -90% reimbursement \$20 co-pay	Subject to deductible - 70% reimbursement 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\$45 Frames\$25 Bifocals..... \$55 Contact Lenses\$45 Trifocals..... \$75 Medically Necessary Contact Lenses.....\$150 VSP providers offer a 20% discount, contact directly at: 1-800-877-7195.</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-\$33,500

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	\$196.43	\$122.77	\$61.38	\$25.70
Employee plus One	384.74	240.46	120.23	50.35
Employee & Family	573.42	358.38	179.19	75.04

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	\$10.15	\$8.12	\$6.09	\$0.00
Employee & spouse	30.92	24.74	18.55	10.62
Employee & one dependent child	30.92	24.74	18.55	10.62
Employee & more than one dependent	41.08	32.86	24.65	20.77

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	\$11.08	\$8.86	\$6.65	\$0.92
Employee plus One Dental & Orthodontia	33.69	26.95	20.22	12.46
Employee & Family Dental & Orthodontia	44.77	35.82	26.86	23.54

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	\$ 5.36	\$ 4.02	\$ 2.68	\$ 1.34

OHIO UNIVERSITY

IMPORTANT BENEFIT NUMBERS

Anthem 

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



EXPRESS SCRIPTS®

www.express-scripts.com

1-866-515-1442

Employee Assistance/ Work Life Program

impactsolutions

www.impactemployeeassistance.com

1-800-227-6007 (24 Hours)

Vision



<https://www.vsp.com/home.html>

1-800-877-7195

Flexible Spending

WageWorks®

www.wageworks.com

1-877-924-3967