

# PPO COVERAGE CHART HIGHLIGHTS

This is only a select list of covered items; view the entire chart online at [www.ohio.edu/hr/benefits/index.cfm](http://www.ohio.edu/hr/benefits/index.cfm)

CATEGORY	CURRENT <i>July 1, 2008- June 30, 2009</i>	NEW <i>Effective July 1, 2009</i>	NO CHANGES to Tier 2
	TIER 1 (In-Network)	TIER 1 (In-Network)	TIER 2 (Out- of-Network)
<b>Deductible</b>	\$0	\$200/\$400	\$400/\$800
<b>Plan Co-Insurance</b>	90% for most categories	90% for most categories	70% for most categories
<b>Employee Co-Insurance</b>	10% for most categories	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.)	\$750/ \$1500 Individual/Family	\$1000/\$2000 Individual/Family	\$1500/\$3000 Individual/Family
<b>Individual Lifetime Maximum Benefits</b>	\$2,000,000	\$3,000,000	
<b>Pre-Existing Condition Limitations</b>	None	None	None
<b>Office Visit</b> (Primary Care, Specialty Care, Physical Therapy, etc.)	\$15 co-pay	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.)	No deductible - 90% reimbursement	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.	No Deductible- 90% reimbursement	\$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>	No deductible \$15 co-pay for office visit 100% reimbursement for eligible procedures	No deductible \$20 co-pay for office visit 100% reimbursement for eligible procedures Expanded to Anthem Blue Cross and Blue Shield Standards	No deductible - 70% reimbursement
<b>Mental Health</b> <b>Inpatient</b> Pre-certification required <b>Outpatient Counseling</b> Pre-certification required	No deductible - 90% reimbursement  <b>First 5 visits of plan year</b> No deductible EAP/Impact Provider - 100% reimbursement <b>Remaining 45 visits</b> No deductible Anthem Network Provider - 70% reimbursement	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 EnvisionRx Options</i> Generic Drug \$10 Brand Name Formulary \$20 Brand Name Non-Formulary \$30 <b>Mail Order Co-pays:</b> <i>Administered by IPS</i> Generic Drug \$15 Brand Name Formulary \$30 Brand Name Non-Formulary \$45	<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	