

# PPO COVERAGE CHART

Effective July 1, 2008- June 30, 2009

CATEGORY	OU PPO	
	TIER 1 (In-Network)	TIER 2 (Out- of-Network)
<b>Deductible</b>	\$0	\$400/\$800
<b>Plan Co-Insurance</b> (% shown unless otherwise noted)	See each category for co-insurance level	
<b>Employee Co-Insurance</b>	See each category for co-insurance level	
<b>Employee Plan year Out-Of-Pocket Maximum</b> (Equal total employee co-insurance for plan year. Does not include deductible, co-pays, services for outpatient mental health/substance abuse or employee contributions.)	\$750/\$1500 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> Unless otherwise specified	\$2,000,000	
<b>Pre-Existing Condition Limitations</b>	None	
<b>OFFICE VISITS (including specialists)</b> Office visit for injury or illness  Office visit for psychiatric medication management	No deductible - \$15 co-pay  No deductible - \$15 co-pay	Subject to deductible - 70% reimbursement  Subject to deductible - 70% reimbursement

## MEDICAL

<b>Ambulance</b> (subject to medical necessity)	No 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.	No deductible \$15 co-pay for office visit 100% reimbursement for other procedures up to dollar maximums at each age interval	No deductible – 70% reimbursement
<b>Chiropractic Services</b>	<i>Subject to medical review after 12 visits</i> \$15 co-pay	
<b>Durable Medical Equipment</b>	No 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.	No deductible – 90% reimbursement	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>	No deductible – 80% reimbursement	Paid as in-network

CATEGORY	OU PPO	
	TIER 1 (In-Network)	TIER 2 (Out- of-Network)
<b>Gynecological Exams/PAP Smears</b> Preventive and Diagnostic	\$15 co-pay for office visit	No deductible – 70% reimbursement.
<b>Hearing</b>	No 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	No deductible – 80% reimbursement  No deductible – 100% reimbursement	Paid as in-network  Paid as in-network
<b>Hospice Services</b> Pre-certification required  In Lieu of Hospitalization	No deductible – 80% reimbursement  No deductible – 100% reimbursement	Paid as in-network  Paid as in-network
<b>Hospital Services</b>	No deductible – 90% reimbursement	Subject to deductible – 70% reimbursement
<b>Life Insurance</b>	2.5 times annual pay to a maximum of \$50,000	
<b>Mammograms</b> Preventive and Diagnostic	No deductible – 100% reimbursement	No deductible – 100% reimbursement
<b>Maternity</b>  Pre and postnatal physician services  Delivery: Vaginal & Cesarean  Labs & Radiology	\$15 co-pay for first visit; afterwards 90% reimbursement  No deductible – 90% reimbursement  No 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	No deductible – 90% reimbursement	Subject to deductible – 70% reimbursement  <b>First 5 visits of plan year</b> No deductible EAP/Impact – 100% reimbursement <b>Remaining 45 visits</b> No deductible Anthem Network Provider – 70% reimbursement Non Anthem Network Provider – 50% reimbursement
<b>Outpatient Services</b> (non-emergency lab, x-ray, diagnostic testing and preadmission testing, allergy injections, serums, medically necessary colonoscopies, etc.) Provider may need to obtain pre-certification per insurance company standards.	No deductible – 90% reimbursement	Subject to deductible – 70% reimbursement
<b>Physical &amp; Occupational Therapy</b>  Inpatient  Outpatient	No deductible – 90% reimbursement  \$15 co-pay	<i>Subject to medical review after 40 visits</i>  Subject to deductible – 70% reimbursement  Subject to deductible – 70% reimbursement

CATEGORY	OU PPO	
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<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> Generic Drug \$10 Brand Name Formulary \$20 Brand Name Non-Formulary \$30 <b>Mail Order Co-pays:</b> Generic Drug \$15 Brand Name Formulary \$30 Brand Name Non-Formulary \$45	
<b>Preventive Care</b> (see plan document for procedure covered and coverage guidelines)	No deductible \$15 co-pay for office visit 100% reimbursement for eligible procedures	No deductible - 70% reimbursement
The following are paid at 100% of allowed charges when billed as preventive/routine. Office visits charges related to these services are subject to plan deductibles, co-insurance, co-pays, etc.		
<ul style="list-style-type: none"> <li>- ADACEL vaccine (tetanus, diphtheria, and acellular pertussis (Tdap) booster vaccine, ages 11-64)</li> <li>- Colonoscopy</li> <li>- Diabetes Screening</li> <li>- Electrocardiograph Stress Test</li> <li>- Gardasil Vaccine (HPV related diseases, ages 9-26)</li> </ul>	<ul style="list-style-type: none"> <li>- GYN exams/pap tests (including pap CA 125)</li> <li>- Hepatitis B Vaccine</li> <li>- HIV Screening</li> <li>- Lipid Panel</li> <li>- Mammograms - see plan chart/book</li> <li>- Pneumococcal - Once for ages 65 &amp; older</li> </ul>	<ul style="list-style-type: none"> <li>- Prostrate Specific Antigen and Digital Rectal Exam</li> <li>- Routine Physical Exam</li> <li>- Sigmoidoscopy</li> <li>- Tetanus Vaccine</li> <li>- Thyroid Panel</li> <li>- Total Cholesterol Screening</li> <li>- Venipuncture</li> </ul>
<b>Second Surgical Opinion</b>	No deductible – 100% reimbursement	Paid as in-network
<b>Speech Therapy</b>	<i>Subject to medical review after 20 visits</i>	
Inpatient	No deductible – 90% reimbursement	Subject to deductible – 70% reimbursement
Outpatient	\$15 co-pay	Subject to deductible – 70% reimbursement
<b>Substance Abuse</b>	2 confinements/lifetime	
<b>Inpatient</b> Pre-certification required	No 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 – 100% reimbursement Anthem Network Provider – 70% reimbursement Non Anthem Network – 50% reimbursement <b>Remaining 45 visits</b> No deductible Anthem Network Provider – 70% reimbursement Non Anthem Network Provider – 50% reimbursement	
<b>Surgery</b> (inpatient, outpatient, doctor’s office & other) Pre-certification required	No deductible – 90% reimbursement	Subject to deductible – 70% reimbursement
<b>TMJ</b>	No deductible – 80% reimbursement \$1,500 lifetime maximum for non-surgical TMJ covered services.	Paid as in-network
<b>Transplants</b> (Transplant program is available)	No deductible – 80% reimbursement No specific maximums	Paid as in-network
<b>Urgent Care Facility</b>	\$15 co-pay	Subject to deductible -70% reimbursement

## VISION

**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.

**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

## DENTAL

<b>Employee Dental</b>	\$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>Employee Orthodontia</b> (optional employee paid benefit)	No deductible 50% co-insurance \$1,000 lifetime maximum
<b>Dependent Orthodontia</b> (optional employee paid benefit)	Benefit per covered person: 50% co-insurance \$1,000 lifetime maximum

## Long Term Disability

60% of pay available from disability insurance company on approval of application  
(OPERS/STRS Disability Retirement may be available per OPERS/STRS eligibility rules)

# OHIO UNIVERSITY

## IMPORTANT BENEFIT NUMBERS

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**Medical** 1-800-599-6903  
**Dental** 470-7250  
**Pre-cert**  
**Nurseline** (24 Hours)



### Mail Order Prescription



**IMMEDIATE PHARMACEUTICAL SERVICES**

33381 WALKER RD. AVON LAKE, OHIO 44012 1.800.233.3872

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

### Employee Assistance/ Work Life Program



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

### Flexible Spending



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