BOT Proposal HEALTH CARE BENEFITS – ATTACHMENT 1
AUGUST 5 2008

SCHEDULE OF BENEFITS
(effective 1-1-09)

This is only a schedule of the Benefits, please refer to the Plan Document for a complete understanding of the Benefits of this Plan. (http://humanresources.utoledo.edu/benefits/benefitplandocs.asp)

Coverage Classification: All Eligible Employees who elect coverage under this Plan
All Covered Expenses are subject to Reasonable and Customary guidelines.

PLAN PROVISIONS	Network PPO	Non-Network PPO	Non-Network EPO/HMO
LIFETIME MAXIMUMS • Plan Per Covered Person	$2,000,000	$1,000,000	No Benefit
• Acquisition of Human Organ Per Covered Person	$15,000		No Benefit
• TMJ Per Covered Person	$750		No Benefit
• Inpatient Chemical Dependency/Substance Abuse	60 day Lifetime Benefit Maximum		No Benefit
DEDUCTIBLES **(Does not apply to the Calendar Year Out-of-Pocket Maximum)** • Calendar Year Per Covered Person (applies to all services unless specified otherwise)	$100	$300	No Benefit
• Per Family of Two (2)	$200	$600	No Benefit
• Calendar Year Per Family of Three (3) or more (applies to all services unless specified otherwise)	$300	$900	No Benefit
OUT-OF-POCKET MAXIMUM **(Copayments for Emergency Room, Urgent Care Facilities, and Physician office visits (Primary Care Physicians and Specialists) will <u>not</u> accumulate toward satisfying these yearly maximums. Deductibles do <u>not</u> apply to the Calendar Year Out-of-Pocket Maximum.)** • Calendar Year Per Covered Person	$1,000	$4,000	No Benefit
• Calendar Year Per Family of Two (2)	$2,000	$6,000	No Benefit

1 the max is per person
cumulative

PLAN PROVISIONS	Network PPO	Non-Network PPO	Non-Network EPO/HMO
• Calendar Year Per Family of Three (3) or more	$3,000	$8,000	No Benefit

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PLAN PROVISIONS	Network PPO	Non-Network PPO	Non-Network EPO/HMO
COPAYMENTS (Does not apply to Calendar Year Deductible or Out-of-Pocket Maximums) • Emergency Room Facility per visit (Copayment waived if admitted within 48 hours)	$75 Copayment Balance paid at 90% Subject to Calendar Year Deductible	$75 Copayment Balance paid at 90% Subject to Calendar Year Deductible	$75 Copayment Balance paid at 90% Subject to Calendar Year Deductible
• Urgent Care Facilities per visit	$35 Copayment Balance paid at 90% Subject to Calendar Year Deductible	$35 Copayment Balance paid at 90% Subject to Calendar Year Deductible	$35 Copayment Balance paid at 90% Subject to Calendar Year Deductible
• Primary Care Providers Physician Office Visit Copayment per visit Includes General Practitioners, Internists, OB/GYN and Pediatricians *(Excluding Mental Health, Chemical Dependency/Substance Abuse, and Preventive Care)*	$15 Copayment Balance paid at 100% Not Subject to Calendar Year Deductible	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	No Benefit
• Specialty Physician Services Physician Office Visit Copayment per visit *(Excluding Mental Health, Chemical Dependency/ Substance Abuse, and Preventive Care)*	$30 Copayment Balance paid at 100% Not Subject to Calendar Year Deductible.	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	No Benefit
• Allergy Serum/Injection	$15 Copayment, (if billed with an Office Visit) Balance paid at 100% (100% coverage when not billed with an Office Visit) Not Subject to Calendar Year Deductible, $1,000 Annual Benefit Maximum	No Benefit (If Office Visit is billed, Office Visit coverage may be reimbursed at the applicable Non-Network Physician Services level.)	No Benefit
• Allergy Testing	$30 Copayment Balance paid at 100%(if billed with an Office Visit) (100% coverage when not billed with an Office Visit) Not Subject to Calendar Year Deductible $500 Annual Benefit Maximum	No Benefit (If Office Visit is billed, Office Visit coverage may be reimbursed at the applicable Non-Network Physician Services level.)	No Benefit

PLAN PROVISIONS	Network PPO	Non-Network PPO	Non-Network EPO/HMO
• Ambulance (Air/Ground)	$25 Copayment, Balance paid at 90% Subject to Calendar Year Deductible	$25 Copayment, Balance paid at 70% Subject to Calendar Year Deductible	No Benefit
• Chemotherapy *(Provided in a Physician's Office)*	$15 (Primary Care Physician) or $30 (Specialist) Copayment 100% up to $150 Balance paid at 90% Subject to Calendar Year Deductible	70% to $4,000 Out-of Pocket Annual Maximum per covered person; Balance paid at 100% Subject to Calendar Year Deductible	No Benefit
• Neuro/Muscular Manipulations or Adjustments (Combined with Kinesiotherapy provided at the University of Toledo Kinesiology Center)	$15 (Primary Care Physician) or $30 (Specialist) Copayment Balance paid at 100% up to $1,000 Annual Benefit Maximum Not Subject to Calendar Year Deductible	70% up to $500 Annual Benefit Maximum Subject to Calendar Year Deductible No benefit for Non-Network Kinesiotherapy	No Benefit
BENEFIT PERCENTAGES • Inpatient Hospital Facility Services *(Requires Prior Authorization)*	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	No Benefit
• Convalescent/Skilled Nursing Facility Services *(Requires Prior Authorization)*	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% 120 day Benefit Maximum Subject to Calendar Year Deductible	70% to $4,000 Out-of Pocket Annual Maximum per covered person Subject to Calendar Year Deductible Balance paid at 100% 120 day Benefit Maximum	No Benefit
• Outpatient Hospital Facility Services *(Requires Prior Authorization for certain services –refer to Section III, "Other Designated Services Requiring Prior Authorization")*	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	No Benefit
• Free Standing Surgical Facilities or Ambulatory Surgical Facilities	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	No Benefit

PLAN PROVISIONS	Network PPO	Non-Network PPO	Non-Network EPO/HMO
• All Other Physician Services, Unless Otherwise Specified in the Plan • Surgeon • Anesthetist • Assistant Surgeon *(Pays 20% of Surgical Allowance)* • Laboratory and X-Ray Services* • Diagnostic Medical Testing* • Inpatient Professional Physician visits • Pre-Admission Testing * Note: If a Network provider uses a non-network provider to interpret the results of any diagnostic medical tests, x-rays or laboratory services – the plan will pay the non-network provider according to the non-network schedule of benefits.	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	70% Subject to Calendar Year Deductible Balance paid at 100%	No Benefit
• Emergency Room Physician	90% Subject to Calendar Year Deductible Balance paid at 100%	90% Subject to Calendar Year Deductible Balance paid at 100%	No Benefit
• Inpatient Mental Health	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	No Benefit
• Inpatient Chemical Dependency/ Substance Abuse	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible 30 day calendar year benefit maximum 60 day Lifetime Benefit Maximum	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible 30 day calendar year benefit maximum 60 day Lifetime Benefit Maximum	No Benefit
• Outpatient Mental Health, Chemical Dependency/Substance Abuse (Requires Prior Authorization for Intensive Outpatient Program (IOP))	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible **30 visit calendar year benefit maximum (for chem & Sub Abuse only)**	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible **30 visit calendar year benefit maximum (for chem & Sub Abuse only)**	No Benefit

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PLAN PROVISIONS	Network PPO	Non-Network PPO	Non-Network EPO/HMO
• Hospice Care	90% Subject to Calendar Year Deductible Balance paid at 100%	70% Subject to Calendar Year Deductible Balance paid at 100%	No Benefit
• Durable Medical Equipment	90% Subject to Calendar Year Deductible Balance paid at 100%	70% Subject to Calendar Year Deductible Balance paid at 100%	No Benefit
• Therapies *(Provided in any Setting)* • Physical *(Limited to 15 visits per Calendar Year additional visits with Prior Authorization)* • Occupational *(Limited to 15 visits per Calendar Year additional visits with Prior Authorization)* • Speech *(Limited to 15 visits per Calendar Year)*	90% to $1,000 Out of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	70% to $4,000 Out-of Pocket Annual Maximum per covered person Balance paid at 100% Subject to Calendar Year Deductible	No Benefit
• Home Health Care *(Requires Prior Authorization)*	90% Subject to Calendar Year Deductible	70% Subject to Calendar Year Deductible	No Benefit
• Chemotherapy *(Provided in an Outpatient Hospital Setting)*	90% Subject to Calendar Year Deductible	70% Subject to Calendar Year Deductible	No Benefit
• Maternity Services	Pays as any other condition	Pays as any other condition	No Benefit
PREVENTIVE CARE SERVICES • Preventive Care Services *(Infant/Birth through 12 month)* *(Includes all services related to preventive care)*	100% up to $1,500 per person per Calendar Year Balance paid at 90% Subject to Calendar Year Deductible	No Benefit	No Benefit
• Preventive Care Services	100% up to $600 per person	No Benefit	No Benefit

PLAN PROVISIONS	Network PPO	Non-Network PPO	Non-Network EPO/HMO
(Age 1 through age 9) *(Includes all services related to preventive care)*	per Calendar Year Balance paid at 90% Subject to Calendar Year Deductible	No Benefit	No Benefit
• Preventive Care Services *(Age 10 and greater)* *(Includes all services related to preventive care)*	100% up to $600 per person per Calendar Year Balance paid at 90% Subject to Calendar Year Deductible	No Benefit	No Benefit
ANNUAL BENEFIT MAXIMUMS Per Covered Person (Subject to the applicable Copayments and Deductibles) • Outpatient Physical Therapy	15 Visits (Additional visits may be available with Prior Authorization)		No Benefit
• Outpatient Speech Therapy	15 Visits		No Benefit
• Outpatient Occupational Therapy	15 Visits (Additional visits may be available with Prior Authorization)		No Benefit
• Skilled Nursing Facility *(Requires Prior Authorization)*	120 Days		No Benefit
• Private Duty Nursing *(Medically Necessary Only - Requires Prior Authorization)*	$5,000		No Benefit
• Inpatient Chemical Dependency/Substance Abuse *(Requires Prior Authorization)*	30 Days (One (1) inpatient day can be converted to two (2) outpatient visits with Prior Authorization)		No Benefit
• Outpatient Mental Health, Chemical Dependency/Substance Abuse	30 Visits		No Benefit
• Neuro-Muscular Manipulation & Kinesiotherapy Therapy (Kinesiotherapy covered only at the University of Toledo's Kinesiotherapy Center)	$1,000	$500 No benefit for Non-Network Kinesiotherapy	No Benefit
• Allergy Serum/Injections	$1,000 No benefit out of network		No Benefit
• Allergy Testing	$500 No benefit out of network		No Benefit

PLAN PROVISIONS	Network PPO	Non-Network PPO	Non-Network EPO/HMO
• Preventive Care Services Routine Mammography	One (1) Per Calendar Year No benefit out of network		No Benefit
• Preventive Care Services Routine Pap Smear	One (1) Per Calendar Year No benefit out of network		No Benefit

OTHER DESIGNATED SERVICES REQUIRING PRIOR AUTHORIZATION

In order for certain services to be covered under this Plan, the services MUST be authorized in advance by the Plan's URO. These services include:

- Bone Marrow Transplants
- Human Organ Transplants
- Convalescent/Skilled Nursing Facility Care
- Home Health Services
- Sleep Lab Studies/Polysomnogram
- Private Duty Nursing
- Inpatient Rehabilitation Admissions
- Tens units
- Blepharoplasty
- Breast Surgeries
- Hyperbaric Oxygen
- MRIs
- Nasal and Sinus Surgery
- Physical or Occupational Therapy (for treatments exceeding fifteen (15) visits)
- Scar Revisions
- Uvulopalatopharyngoplasty (UPPP) (and all other surgical and non-surgical treatments for sleep disturbances)
- Intensive Outpatient Program (IOP) for Psychiatric/Chemical Dependency and Substance Treatment
- Elective Hospital Admissions
- Emergency Hospital Admissions