The University of Akron
Medical & Prescription Drug Plan Summary and Comparison for 2012[i]

Covered Service[ii]	PPO Gold 90		PPO Blue 80	
	In Network	Out of Network	In Network	Out of Network
Office Visit[iii]	$20 Co-pay	70% of R&C after deductible	$25 Co-pay	60% of R&C after deductible
Specialist Physicians	$25 Co-pay	70% of R&C after deductible	$35 Co-pay	60% of R&C after deductible
Urgent Care	$35 Co-pay	70% of R&C after deductible	$50 Co-pay	60% of R&C after deductible
Emergency Room	*If admitted to the hospital from the emergency room, co-pay waived. In an emergency, always go to the nearest hospital. Benefits are always paid at in-network levels in emergency situations.*			
	$75 Co-pay	$75 Co-pay	$100 Co-pay	$100 Co-pay
Deductible (Single/Family)	$200/$400	$400/$800	$400/$800	$800/$1,600
Annual Out-of-Pocket Max (Single/Family)	$1,500/$3,000	$3,000/$6,000	$3,000/$6,000	$6,000/$12,000
Lifetime Benefit Maximum	*Unlimited*			
Anesthesia	90% after deductible	70% of R&C after deductible	80% of UR&C after deductible	60% of R&C after deductible
Allergy Testing	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Ambulance Services	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Behavioral Health Services -Inpatient	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Behavioral Health Services -Outpatient	*Employees and family members have access to six counseling sessions per issue at no-cost through IMPACT, the University's Employee Assistance Program. Contact IMPACT at 800-227-6007 for more information.*[iv]			
	$20 Co-pay	70% of R&C after deductible	$25 Co-pay	60% of R&C after deductible
Behavioral Health Services –Partial Hospitalization	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Diagnostic Testing	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Durable Medical Equipment	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Home Health Care Services	*Home Health Care Services are limited to 120 days per plan year*			
	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Hospice Care[v]	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Immunization[vi]	100%	70% of R&C after deductible	100%	60% of R&C after deductible
In-Hospital Physician visits	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Inpatient Hospitalization	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible

Medications – Outpatient[vii]	*Some medications are covered under the prescription drug plan, not medical insurance plan. Contact EnvisionRx Options for information.*			
	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Outpatient Procedures	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Pre-Admission Testing	90% after deductible	70% of R&C after deductible	80% of UR&C after deductible	60% of R&C after deductible
Prescription Drug	*Prescription Drugs coverage is provided under all medical plans and administered by EnvisionRx Options. See chart below or visit www.uakron.edu/hr/benefits.*			
Private Duty Nursing	90% after deductible	70% of R&C after deductible	80% of UR&C after deductible	60% of R&C after deductible
Radiation Therapy/ Chemotherapy	90% after deductible	70% of R&C after deductible	80% of UR&C after deductible	60% of R&C after deductible
Rehabilitative Services	*Combined maximum of 60 visits per plan year for: acupuncture, cardiac rehabilitation therapy, occupational therapy, chiropractic therapy, physical therapy, and speech therapy services.*			
	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Routine Gynecological Exam[viii]	100%	70% of R&C after deductible	100%	60% of R&C after deductible
Routine Mammography[ix]	100%	70% of R&C after deductible	100%	60% of R&C after deductible
Routine Physical Exam[x]	100%	70% of R&C after deductible	100%	60% of R&C after deductible
Routine Testing[xi]	100%	70% of R&C after deductible	100%	60% of R&C after deductible
Skilled Nursing Facility	*Skilled Nursing care facilities services are covered for up to 120 days per plan year.*			
	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Surgical	90% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
Well Baby/Child Care[xii]	100%	70% of R&C after deductible	100%	60% of R&C after deductible

EnvisionRx Options

	Retail (30 Day Supply)	Mail Order (90 Day Supply)	Retail (30 Day Supply)	Mail Order (90 Day Supply)
Generic Prescription Drugs (Tier 1)	$10	$25	$12	$30
Preferred Brand Prescription Drugs (Tier 2)	20% ($50 Max)	20% ($125 Max)	25% ($60 Max)	25% ($150 Max)
Non-Preferred Brand Prescrip. Drugs (Tier 3)	25% ($70 Max)	25% ($175 Max)	35% ($100 Max)	35% ($250 Max)
Specialty Prescription Drugs (Tier 4)	25% ($125 Max)	--	35% ($150 Max)	--

- **Co-pay:** A predetermined dollar amount or percentage that you pay for a particular service.
- **Deductible:** The amount you pay each year before your health plan starts paying benefits.
- **Co-insurance:** When a plan requires coinsurance, it means that after you meet your deductible, you and the University share the cost of the services you receive—you pay for part of the allowed charge, and the University pays for the rest of the allowed charge. The amount that you and the University each pay varies by plan and covered services.
- **Out-of-pocket max:** The most you will pay in deductibles, coinsurance, and any other covered out-of-pocket expenses during a plan year. Once you reach the maximum, the University pays 100% of the contracted fee for covered expenses for the remainder of the year.
- **R&C:** Abbreviation for reasonable and customary.

Notable Northeast Ohio In-Network Hospitals

Cleveland Clinic

SUMMA Health System

AKRON GENERAL MEDICAL CENTER

MetroHealth

Akron Children's Hospital

University Hospitals

MERCY MEDICAL CENTER
A Ministry of the Sisters of Charity Health System

Wooster Community Hospital

Dunlap COMMUNITY HOSPITAL

Preferred Provider Organization Network Access

Within Ohio

SC Plus

www.summacare.com
800-753-8429

Outside of Ohio

PHCS MultiPlan

www.multiplan.com
888-342-7427

In an emergency, always go to the nearest hospital.
Benefits are paid at in-network levels in emergency situations.

Nurse Line

Call 800-379-5001
Available 24 Hours a Day, 7 Days a Week

Learn how to treat minor injuries without spending unnecessary time in the emergency room. Learn more about a new drug or surgery your doctor recommends. To get answers to your healthcare questions, call the SummaCare 24-Hour Nurse Line. Experienced registered nurses have accurate, up-to-date information about almost any health topic. A nurse can answer your questions, offer support and help you make decisions about any non-emergency health situation.

Medical Insurance Annual Employee Contribution

PPO 90% Gold Plan							
	$0.00 – $28000	$28000.01 – $33,000	$33.000.01 - $43,000	$43,000.01 – $59,000	$59,000.01 – $80,000	$80,000.01 - $106,000	$106,000+
Employee Only	$756	$819	$882	$945	$1,008	$1,071	$1,134
Employee + Spouse/ Domestic Partner	$1,512	$1,638	$1,764	$1,890	$2,016	$2,142	$2,267
Employee + Children	$1,437	$1,557	$1,677	$1,796	$1,916	$2,036	$2,156
Employee + Spouse/ Domestic Partner + Children	$2,193	$2,376	$2,558	$2,741	$2,924	$3,107	$3,289
Adult Child (Age 26 & 27)	Additional $2,520 Annually						

PPO 80% Blue Plan	
	All Salaries
Employee Only	$283
Employee + Spouse/ Domestic Partner	$565
Employee + Children	$537
Employee + Spouse/SSDP + Children	$820
Adult Child (Age 26 & 27)	Additional $2,260 Annually

Dental Insurance Plan Summary

Covered Service	Delta Dental of Ohio Dental Insurance Plan		
	Delta Dental PPO Provider	Delta Dental Premier Network	Out of Network
Class 1 Services (Preventive Care)	100%	100%	100% of Delta Dental's Maximum Allowed Amount
Class 2 Services (Basic Services)	70% after deductible	70% after deductible	70% of Delta Dental's Maximum Allowed Amount
Class 3 Services (Major Services)	50% after deductible	50% after deductible	50% of Delta Dental's Maximum Allowed Amount
Class 4 Services (Orthodontia, Age 19)	50% after deductible	50% after deductible	50% of Delta Dental's Maximum Allowed Amount
Dentist Discount Rates	Best Discounts	Good Discounts	No Discounts
Balance Billing Protection	Yes	Yes	No
Deductible (Per Person)	$50		
Orthodontia Lifetime Max.	$1,000		
Annual Benefit Maximum	$1,250		

Dental Insurance Annual Employee Contribution

	Delta Dental of Ohio Dental Insurance Plan
Employee	$0
Employee + Spouse/SSDP	$0
Employee + Child(ren)	$0
Employee + Spouse/SSPD + Child(ren)	$0

Vision Insurance Plan

Covered Service	VSP (Vision Service Plan) Signature Plan	
	VSP Providers (In-Network)	**Non-VSP Provider, Maximum Re-imbursement** (Out of Network)
Eye Exam	$10 Co-pay (Every Plan Year)	Up to $35
Prescription Glasses…	$15 Co-pay	--
…Lenses	100% (Every Plan Year) *Single vision, lined bifocal, lined trifocal lenses, polycarbonate lenses and scratch coating*	Single vision lenses: Maximum $25 Lined bifocal lenses: Maximum $40 Lined trifocal lenses: Maximum $55
…Frame	$130 Allowance, 20% Off Amount Over Allowance (Every Other Plan Year)	Frames: Maximum $45
Contact Lens	No Co-pay. *$130 allowance for contacts and the contact lens exam. Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses.*	Elective Contact Lenses: Maximum $105.00 Medically Necessary Contacts : Maximum $210
Frequency	Exam and lenses once every 12 months; and a frame once every 24 months. Contact lenses are in lieu of lenses and frame.	Exam and lenses once every 12 months; and a frame once every 24 months. Contact lenses are in lieu of lenses and frame.
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price from contracted facilities.	None
VSP Service Guarantee	Yes	None

Vision Insurance Annual Employee Contribution

	VSP (Vision Service Plan) Signature Plan
Employee	$113
Employee + One	$226
Employee + Two or More	$330

Disability & Life Insurance Plans

	Short Term Disability
Salary Replacement	60% Salary Replacement, $1,400 Maximum Weekly Benefit Must Exhaust Sick Leave
Waiting Period	14 Days for Injury 28 Days for Illness (including Pregnancy)
Preexisting Limitation	12/12
Employee Cost	Varies by Age and Salary 100% Employee Funded
Vendor	Dearborn National

	Long Term Disability
University Provided	60% Salary Replacement, $5,000 Monthly Benefit Maximum Benefit Pays after 6 month waiting period from last day worked. Must Exhaust Sick Leave
Supplemental Option	70% Salary Replacement, $6,000 Monthly Benefit Maximum Benefit pays after 6 month waiting period from last day worked Must Exhaust Sick Leave
Preexisting Limitation	3/12
Employee Cost	60% Option: $0, 100% University Funded 70% Option: Varies. Employee pays difference between 60% and 70% option Costs Varies by Salary
Vendor	UnitedHealthCare

	Life Insurance
University Provided	Two Times Your Annual Salary Maximum $100,000
Supplemental Options	Employees may purchase 1 to 5 times their annual salary up to $500,000 without an “evidence of insurability” medical exam. Employees may purchase 1 to 5 times their annual salary up to $1,000,000 with a successful “evidence of insurability” medical exam. Costs Varies by Age and Salary.
Accelerated Benefit	Available if diagnosed as terminally ill (12 months or less life expectancy). Contact Minnesota Life for details.
Vendor	Minnesota Life

	Accidental Death and Dismemberment Insurance
University Provided	Two Times Your Annual Salary Maximum $100,000
Vendor	Minnesota Life

[i] These charts and hospital network summary have been prepared by The University of Akron to provide a very broad overview of the plan options available. Please refer to the specfic plan documents and official SCPlus network directory for more detailed information. Should any information deffer between this sheet and the official plan documents, the plan documents shall prevail.

[ii] Eligibility Provisions: Initial Eligibility 1st of month following date of hire.

[iii] This co-pay applies to family practitioners, general practitioners, internal medicine practitioners, OBGYN practitioners, pediatricians, and retail health clinics (or "minute clinic") facilities,

[iv] When possible, IMPACT will refer callers to an in-network behavioral health provider to ensure the maximum benefit coordination possible between the EAP and the medical insurance.

[v] Life expectancies 6 months or less

[vi] As determined by the Center for Disease Control and Prevention's "Advisory Committee on Immunization Practices" (ACIP)

[vii] Injectables/oral/intravenous (including chemotherapy) medications dispensed on an outpatient (e.g.: provider's office) basis.

[viii] Preventative care includes: one OG/GYN exam per plan year.

[ix] One baseline age 35-39; One per year ages 40 and older

[x] Routine Physical exam 1 per plan year

[xi] Per U.S. Preventative Services Task Force Recommendations Schedule Evidenced Based "A" & "B" Services, Evidence-informed preventative screening for infants, children & adolescents provided in guidelines supported by Health Resources and Services Administration

[xii] Per Recommendations for Preventive Pediatric Health Care schedule Bright Futures/American Academy of Pediatrics