

**University Hospitals Medical Plan**  
**Schedule of Benefits – Traditional PPO Plan**  
**Administered by Anthem Blue Cross and Blue Shield**  
**Effective: January 1, 2010**

	<b>TIER 1 UHHS EXCLUSIVE NETWORK</b>	<b>TIER 2 MODIFIED ANTHEM NETWORK</b>	<b>TIER 3 OUT-OF-NETWORK</b>
<b>Benefit Period:</b> Calendar Year			
<b>Annual Deductible</b> Per Individual Per Family	\$200 \$400 Applies to inpatient and outpatient facility services only	\$400 \$800 Applies to inpatient and outpatient facility services only	\$1,000 \$2,000
<b>Coinsurance</b>	\$0	You pay 20%	You pay 50% of R&C <sup>1</sup>
<b>Maximum Out-of-Pocket for Coinsurance</b> (Deductibles and Copayments do not count toward the Maximum Out-of-Pocket) Per Individual Per Family Note: Tier 2 and Tier 3 Out-of-Pocket limits accumulate separately.	None None	\$2,500 \$5,000	\$5,000 \$10,000
<b>Maximum Lifetime Benefits</b>	\$2,500,000		
<b>COVERAGE LEVELS</b>			
<b>Preventive Services</b>	<b>You Pay:</b>	<b>You Pay:</b>	<b>You Pay:</b>
General physical exams (includes routine EKG, Chest X-Ray, & routine lab tests such as complete blood count, comprehensive metabolic panel, & urinalysis)	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
Routine Preventive Screenings (e.g., Cholesterol Test, Bone Density Test, pelvic exam, PAP test, Prostate Specific Antigen Test, Routine Colorectal Cancer Screening & related lab tests)	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
Routine Mammogram	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
Well Baby/Well Child Care Visits	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
Immunizations	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
Routine vision exam (one per Benefit Period) Note: Preventive services are only available when accessed through a Primary Care Physician or OB/GYN.	\$0	\$0	\$0 (Maximum benefit is 100% of R&C <sup>1</sup> )
<b>Practitioner Services</b>			
Primary care office visit	\$20 Copayment	\$20 Copayment	Deductible and 50% of R&C <sup>1</sup>
Specialist office visit	\$40 Copayment	\$40 Copayment	Deductible and 50% of R&C <sup>1</sup>
OB/GYN visit	\$20 Copayment	\$20 Copayment	Deductible and 50% of R&C <sup>1</sup>
Surgical services	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
Diagnostic services administered in office			
Laboratory tests	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
X-ray exams, imaging exams and ultrasound	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
Maternity services	\$0 (After initial \$20 Copayment)	\$0 (After initial \$20 Copayment)	Deductible and 50% of R&C <sup>1</sup>
Chiropractic care (\$500 maximum per Benefit Period)	\$40 Copayment	\$40 Copayment	Deductible and 50% of R&C <sup>1</sup>

<sup>1</sup> You will be responsible for paying any amount in excess of R&C in addition to the Deductible and Coinsurance.

<sup>2</sup> Waived if admitted.

<sup>3</sup> The Coinsurance does not apply toward the Maximum Out of Pocket.

<sup>4</sup> This benefit is only available when using physicians in the MacDonald Fertility and IVF Program.

**MAXIMUM AGE FOR DEPENDENT CHILDREN: Age 19, or age 25 if a Full-time student (covered until the end of the calendar year).**

**Failure to obtain required Prior Authorization in advance will result in a \$300 penalty to the member, after which Out-of-Network benefit levels will apply.**

**Complete benefit descriptions, services requiring Prior Authorization, and exclusions are contained in the UH Summary Plan Description (SPD) and any applicable Summary Material Modification. In situations where there are differences between this Schedule of Benefits and the Summary Plan Description, the SPD will govern.**

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<b>Home Health Services</b> (50 visits per Benefit Period)	\$0	20%	Deductible and 50% of R&C <sup>1</sup>
<b>Therapy Services</b> Speech Therapy for medical, non-developmental conditions (30 visits per Benefit Period)	<b>You Pay:</b> \$20 Copayment	<b>You Pay:</b> \$20 Copayment	<b>You Pay:</b> Deductible and 50% of R&C <sup>1</sup>
Physical/Occupational Therapy for medical conditions only (30 visits per Benefit Period combined)	\$20 Copayment	\$20 Copayment	Deductible and 50% of R&C <sup>1</sup>
<b>Outpatient Facility Services</b> Diagnostic Services, including pre-admission testing	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
Surgical Services	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
Urgent Care Visit Practitioner Services All other Services	\$50 Copayment \$0	\$50 Copayment \$0	Deductible and 50% of R&C <sup>1</sup> Deductible and 50% of R&C <sup>1</sup>
Emergency Services (including Practitioner's Services)	\$100 Copayment <sup>2</sup>	\$100 Copayment <sup>2</sup>	\$100 Copayment <sup>2</sup>
Ambulance transportation to and/or from a hospital	\$0	\$0	\$0
<b>Inpatient Facility Services</b> Semi-private accommodations in a Hospital	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
Intensive Care in a Hospital	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
Inpatient Rehabilitation (60 days per Benefit Period)	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
Skilled Nursing Rehabilitation (90 days per Benefit Period)	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
<b>Bariatric (Obesity) Surgery</b> (\$10,000 lifetime max benefit)	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
<b>Transplant Services</b> Prior Authorization is required for all transplant services. Please see SPD for details.	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
<b>Infertility Treatment Services</b> (\$10,000 lifetime max benefit) Refer to Summary Plan Description for coverage limitations.	50% <sup>4</sup>	Not covered	Not covered
<b>Hospice Care</b>	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
<b>Hearing Aid Services</b> Audiometric Test (One test per year)	\$20 Copayment	\$20 Copayment	\$20 Copayment
Hearing Aid (\$2,000 maximum benefit. One hearing aid every four years.)	50% <sup>3</sup>	50% <sup>3</sup>	50% <sup>3</sup>
<b>Medical Supplies, Equipment, and Appliances</b> Durable Medical Equipment (\$4,000 maximum per Benefit Period)	10% <sup>3</sup>	10% <sup>3</sup>	Deductible and 50% of R&C <sup>1,3</sup>
Prosthetic Devices (\$4,000 maximum per Benefit Period)	10% <sup>3</sup>	10% <sup>3</sup>	Deductible and 50% of R&C <sup>1,3</sup>
Prosthetic Limbs (\$10,000 maximum per Benefit Period)	10% <sup>3</sup>	10% <sup>3</sup>	Deductible and 50% of R&C <sup>1,3</sup>
Oxygen	\$0	\$0	Deductible and 50% of R&C <sup>1</sup>
<b>Mental Health and Substance Abuse</b> Inpatient	Deductible and \$0	Deductible and 20%	Deductible and 50% of R&C <sup>1</sup>
Outpatient Partial Hospitalization, Intensive Outpatient Services, and Ambulatory Detoxification Services	\$40 Copayment See SPD for Details	\$40 Copayment See SPD for Details	Deductible and 50% of R&C <sup>1</sup> See SPD for Details

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**University Hospitals Medical Plan**  
**Schedule of Benefits – Traditional Plan Prescription Drug Coverage**  
**Administered by Medco Health Solutions**  
**Effective: January 1, 2010**

	GENERIC PRESCRIPTION	FORMULARY BRAND NAME PRESCRIPTION	NON-FORMULARY BRAND NAME PRESCRIPTION
<b>Benefit Period:</b> Calendar Year			
<b>Annual Maximum Out-of-Pocket</b> Per Individual	\$2,500		
<b>Network Retail Coinsurance</b> (30 day supply per Prescription)	<b>You Pay:</b> \$10*	<b>You Pay:</b> 30% \$30 minimum* \$100 maximum	<b>You Pay:</b> 50% \$70 minimum* \$200 maximum
<b>Network Mail Order Coinsurance</b> (90 day supply per Prescription)	<b>You Pay:</b> \$25*	<b>You Pay:</b> 20% \$75 minimum* \$250 maximum	<b>You Pay:</b> 50% \$175 minimum* \$500 maximum
<b>Non-Network Retail</b>	Not covered		
<b>Generic Drug Program</b>	Generic Drugs will be dispensed whenever permitted by state and federal law.  If the Member or Physician requests a Brand Name Drug when a Generic equivalent is available, the Member will be required to pay the difference in cost between the Brand Name Drug and the Generic Drug, in addition to the Brand Name coinsurance payment.		
<b>Prior Authorization</b>	Prior Authorization is the process of obtaining approval of benefits before certain prescriptions may be filled. Prior authorization must be obtained by your physician in order for you to receive benefits for these drugs.  A listing of Medco's drugs which require Prior Authorization is available at <a href="http://www.Medco.com">www.Medco.com</a> .		
<b>Quantity Limits</b>	Certain prescription drugs have specific Quantity Limits per prescription per month. A listing of Anthem's drugs which are subject to Quantity Limits is available at <a href="http://www.Medco.com">www.Medco.com</a> .		
<b>Step Therapy</b>	Certain prescription drugs require Step Therapy, which is a process where you may be required to first try an alternative therapy before your prescription benefits may be used toward the requested medication.  A listing of Medco's drugs which require Step Therapy is available at <a href="http://www.Medco.com">www.Medco.com</a> .		
<b>Coverage Exceptions</b>	In certain circumstances, if a member is unable to tolerate a Formulary medication for medical reasons, a member may be eligible to obtain Non-Formulary medications at the Formulary benefit level. To apply for this exception, your physician must contact Medco to provide documentation of the medical reasons for the requested exception.		
<b>Formulary Modifications</b>	In categories of specialty medications where no alternative is available in Medco's Formulary, certain Non-Formulary alternatives have been designated as Formulary medications in the UH Plan. Your physician can contact Medco for assistance with locating a Formulary alternative.		
<b>Contraceptives</b>	Contraceptive injectibles, oral, and patch are covered. Contraceptive implants and devices are covered under the medical benefit.		
<b>Infertility Drugs</b> (50% Paid by Member up to a lifetime maximum benefit of \$5,000.)	This coinsurance does not count toward the annual maximum out-of-pocket limit.		
<b>Diabetic Supplies</b> (Maximum 200 meter strips per individual per month will be covered)	Meter strips, lancets, urine test strips, syringes, and one blood glucose meter per year will be covered at one Generic coinsurance payment per Prescription.		
<b>Smoking Cessation Drugs</b> (Maximum \$250 lifetime benefit)	Covered prescriptions include Bupropion, Chantix, Nicoderm CQ, Nicotine Patch, Nicotrol, and Zyban.		

\*If the full cost of the drug is less than the minimum, you pay the full cost of the drug.

Complete benefit descriptions and exclusions are contained in the Summary Plan Description, which will govern.