

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

	TIER 1 UH EXCLUSIVE NETWORK	TIER 2 MODIFIED ANTHEM NETWORK	TIER 3 OUT-OF-NETWORK
Benefit Period: Calendar Year			
Annual Deductible (Includes medical and prescription drugs) Per Individual Per Family		\$1,500 \$3,000	
Coinsurance	You pay 0%	You pay 40%	You pay 50% of R&C ¹
Maximum Out-of-Pocket for Coinsurance (medical only) (Deductibles do not count toward the Maximum Out-of-Pocket) Per Individual Per Family Note: Tier 1 maximum out-of-pocket limits accumulate with Tier 2 maximum out-of-pocket limits. All Tier 2 and Tier 3 Out-of-Pocket limits accumulate separately.	None None	\$2,500 \$5,000	\$5,000 \$10,000
Maximum Lifetime Benefits	\$2,500,000		
Health Savings Account – Annual Employer Contribution Single (pro-rated based upon plan entry date) Family (pro-rated based upon plan entry date)		\$750 \$1,500	
Health Savings Account Maximum Employee Contribution Individual Family		\$2,300 \$4,650	
COVERAGE LEVELS			
Preventive Services General physical exams (includes routine EKG, Chest X-ray, & routine lab tests such as complete blood count, comprehensive metabolic panel, & urinalysis) 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) Routine Mammogram (One exam per Benefit Period) Well Baby/Well Child Care Visits Immunizations Routine vision exam (One exam per Benefit Period) Note: Preventive services are only available when accessed through a Primary Care Physician or OB/GYN.	You Pay: \$0 \$0 \$0 \$0 \$0	You Pay: \$0 \$0 \$0 \$0	You Pay: Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ \$0 (Maximum benefit is 100% of R&C) ¹
Practitioner Services Primary care office visit Specialist office visit OB/GYN visit Surgical services Diagnostic services Laboratory tests X-ray exams, imaging exams and ultrasound Maternity services Chiropractic care (\$500 maximum per Benefit Period)	Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0%	Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0% Deductible and 0%	Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹ Deductible and 50% of R&C ¹
Home Health Services (50 visits per Benefit Period)	Deductible and 0%	Deductible and 40%	Deductible and 50% of R&C ¹

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

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

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

³ 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.

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

	GENERIC PRESCRIPTION	FORMULARY BRAND NAME PRESCRIPTION	NON-FORMULARY BRAND NAME PRESCRIPTION
Benefit Period: Calendar Year			
Annual Deductible (Includes medical and prescription drugs)			
Single		\$1,500	
Family		\$3,000	
Annual Maximum Out-of-Pocket (prescription drugs only) (Deductibles do not count toward the Maximum Out-of-Pocket)			
Single		\$1,800	
Family		\$3,600	
Network Retail Coinsurance (30 day supply per Prescription)	You Pay: \$10*	You Pay: 30% \$30 minimum* \$100 maximum	You Pay: 50% \$70 minimum* \$200 maximum
Network Mail Order Coinsurance (90 day supply per Prescription)	You Pay: \$25*	You Pay: 20% \$75 minimum* \$250 maximum	You Pay: 50% \$175 minimum* \$500 maximum
Non-Network Retail	Not covered		
Generic Drug Program	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.		
Prior Authorization	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 www.Medco.com .		
Quantity Limits	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 www.Medco.com .		
Step Therapy	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 www.Medco.com .		
Coverage Exceptions	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.		
Formulary Modifications	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.		
Contraceptives	Contraceptive injectibles, oral, and patch are covered. Contraceptive implants and devices are covered under the medical benefit.		
Infertility Drugs	50% Paid by Member up to a lifetime maximum benefit of \$5,000		
Diabetic Supplies (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.		
Smoking Cessation Drugs (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.