UNIVERSITY OF ST. THOMAS

Effective July 1, 2011 **Summary of Benefits – 90/70 Plan** **Group # H870582**

LEVEL I PROVIDERS: Hospitals (Inpatient/Outpatient), Inpatient facilities (i.e., Rehabilitation Facilities, Skilled Nursing Facilities and Hospice), Inpatient and Outpatient facilities for Treatment of Mental and Nervous Disorders, Chemical Dependency, Drug and Substance Abuse, Ambulatory Surgery Centers, Dialysis Clinics and other Inpatient or freestanding facilities.
LEVEL II PROVIDERS: Physicians and all other Providers of service. The "Level II PPO Benefit" also applies in the following exception: If a Covered Person seeks treatment in a Hospital or Ambulatory Surgery Center, and required services are rendered by a Non-PPO radiologist, anesthesiologist, pathologist, assistant surgeon, on-call Physician/specialist or emergency room Physician.

MEDICAL CARE	Level I Benefit	Level II PPO Benefit	Level II Non-PPO Benefit
Plan Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Maximum Benefit	$2,000,000	$2,000,000	$2,000,000
Calendar Year Deductible (Carryover Deductible applies)	$0	$0	$2,500 ($7,500 Family)
Annual Out-of-Pocket Maximum (Excluding Deductible and Copays)	$3,000 ($9,000 Family)	$3,000 ($9,000 Family)	$6,000 ($18,000 Family)
WELLNESS BENEFITS			
Routine Preventive Care			
– Routine Physical Exam	N/A	100% after $15 Copay	70% after Deductible
– Annual Well Woman Exam	N/A	100% after $15 Copay	70% after Deductible
– Annual Mammogram (Age 35 and older or family history)	100%	100%	70% after Deductible
– Bone Density Test	100%	100%	70% after Deductible
– Prostate exam and PSA (age 50 and older or with a family history of prostate cancer)	100%	100%	70% after Deductible
– Well Baby/Well Child Care	N/A	100% after $15 Copay	70% after Deductible
– Routine Immunizations	N/A	100%	70% after Deductible
– Flu/pneumonia vaccines	N/A	100%	70% after Deductible
– Lab/X-ray and routine diagnostic testing and other medical screenings	100%	100%	70% after Deductible
Routine and Diagnostic Colonoscopy (age 50 and older or family history)	100%	100%	70% after Deductible
BENEFITS			
Inpatient Hospital Expenses Notification to HealthWatch is required within 48 hours of hospital admission or $250 penalty	90% (Facility charges)	90%	70% after Deductible
Inpatient Confinement Copay	$250	N/A	N/A
Hospital Emergency Room (Copay waived if admitted)	90% after $100 Copay	90% (All related charges)	70% after Deductible (All related charges)
Ambulance	90%	90%	90%
Physician Office Visit (exam only)	N/A	100% after $15 Copay*	70% after Deductible
- Allergy Injections	N/A	100%	70% after Deductible
- All other Office Services	N/A	90%	70% after Deductible
One Call Medical Radiological Benefit (CT, MRI, and PET scans)	N/A	100%; Copay waived	N/A
Lab/X-ray (Physician Office, Outpatient Hospital, Independent Lab)	90%	90%	70% after Deductible
Outpatient Hospital/Ambulatory Surgery (UR Notification required)	90% (Facility charges)	90%	70% after Deductible

Level I Covered Charges and Level II PPO and Non-PPO Covered Charges apply to satisfy the Level I/Level II PPO Annual Out-of-Pocket Maximum. Only Level II Non-PPO Covered Charges apply to satisfy the Level II Non-PPO Annual Out-of-Pocket Maximum. Calendar Year Maximum Benefits are determined by combining Level I (Hospital/Facility) and Level II (PPO and Non-PPO) Covered Charges.

* **Office Visit Copay covers exams only.**

UNIVERSITY OF ST. THOMAS

Effective July 1, 2011 | **Summary of Benefits Continued** | **Group # H870582**

MEDICAL CARE	Level I Benefit	Level II PPO Benefit	Level II Non-PPO Benefit
Maternity Facility Charges Physician Charges	 100% N/A	 N/A 90% (Office Visit Copay applies to initial OB Exam)	 N/A 70% after Deductible
Routine Newborn Care (Payable under covered mother's claim) (Pediatric care to date of mother's discharge.)	100% (Facility charges)	90%	70%; Deductible waived
Mental & Nervous Conditions, Chemical Dependency			
- Inpatient	90% (Confinement Copay applies)	90%	70% after Deductible
- Outpatient Therapy	100% after $15 Copay	100% after $15 Copay	70% after Deductible
- Residential Treatment Center	90%	90%	70% after Deductible
- Day Treatment	90%	90%	70% after Deductible
- Office Visit	N/A	100% after $15 Copay	70% after Deductible
Physical Therapy/Occupational Therapy/Speech Therapy/Cardiac Rehabilitation	90%	90%	70% after Deductible
Combined Calendar Year Maximum Benefit for Physical, Speech and Occupational Therapies	60 visits	60 visits	60 visits
Chiropractic Services Calendar Year Maximum Benefit	N/A	90% $2,000	70% after Deductible $2,000
Acupuncture Calendar Year Maximum Benefit	N/A	90% $1,000	70% after Deductible $1,000
Sleep Disorders/Sleep Apnea			
- Office Visit (exam only)	N/A	100% after $15 Copay	70% after Deductible
- All other Covered Services	90%	90%	70% after Deductible
Calendar Year Maximum Benefit (Maximum applies to age 19 and older)	$5000	$5000	$5000
Temporomandibular Joint (TMJ) Syndrome	90%	90%	70% after Deductible
Calendar Year Maximum Benefit	$2,000	$2,000	$2,000
Home Health Care Calendar Year Maximum	90% 100 visits	90% 100 visits	70% after Deductible 100 visits
Home Infusion Therapy	N/A	90%	70% after Deductible
Skilled Nursing Facility/Rehabilitation Facility	90% (Confinement Copay applies)	90%	70% after Deductible
Calendar Year Combined Maximum	100 days	100 days	100 days
Chemotherapy, Dialysis, Radiation Therapy/Infusion Therapy	90%	90%	70% after Deductible
Hospice	90%	90%	70% after Deductible
DME, Medical Supplies, Prosthetics	90%	90%	70% after Deductible
All Other Covered Charges	90%	90%	70% after Deductible

PRESCRIPTION DRUG PLAN	
Envision Retail Pharmacy Prescription Drug Card Copays 30-day supply limit	$10 Generic Copay $25 Formulary Brand Copay $35 Non-Formulary Brand Copay
Envision Mail Order Service Copays 90-day supply limit	$20 Generic Copay $50 Formulary Brand Copay $70 Non-Formulary Brand Copay
Envision Specialty Pharmacy 30-day supply limit	20% Copay to maximum Copay of $150 per prescription

PLEASE CONTACT GROUP & PENSION ADMINISTRATORS OR THE PPO NETWORK AT THE PHONE NUMBER OR WEBSITE SHOWN ON YOUR PLAN I.D. CARD FOR INFORMATION ABOUT WHICH PROVIDERS ARE INCLUDED AS LEVEL I OR LEVEL II PROVIDERS.

University of St. Thomas believes this Employee Benefit Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at **713-525-3813**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.