

Huntington University Health Plan Summary - Effective 2/1/2007

| Services | Current Plan |
|--|---|
| Deductible per person per Calendar Year | \$600 |
| Deductible per Family Unit per Calendar Year | \$1,200 |
| Maximum Out-of-Pocket per person Per Cal Yr <i>(not including deductible)</i> | \$1,300 in-network / \$2,000 out-of-network |
| Maximum Out-of-Pocket per Family Unit Per CalYr <i>(not including deductible)</i> | \$2,600 in-network / \$4,000 out-of-network |
| Maximum Lifetime Benefit Amount while covered under this plan | \$2,000,000 |
| Benefit Limits | |
| Hospital Room & Board <i>(semi-private room rate or ICU charge)</i> | Deductible 80% / Deductible 70% |
| Hospital Miscellaneous | Deductible 80% / Deductible 70% |
| Inpatient Physician Services <i>(Primary Care or Specialist)</i> | Deductible 80% / Deductible 70% |
| Physician Office Services <i>(Primary Care or Specialist)</i> | Deductible 80% / Deductible 70% |
| Surgical and Anesthesia Services | Deductible 80% / Deductible 70% |
| Diagnostic X-Ray & Laboratory Services | Deductible 80% / Deductible 70% |
| Skilled Nursing Facility, Extended Care Facility <i>(90 days per Calendar Year)</i> | 100% |
| Home Health Care | Deductible 80% / Deductible 70% |
| Therapy Services | Deductible 80% / Deductible 70% |
| Emergency Room | Deductible 80% / Deductible 70% |
| Urgent Care Facility | Deductible 80% / Deductible 70% |
| Chiropractic Services <i>(\$500 Calendar Year Maximum)</i> | Deductible 80% / Deductible 70% |
| Ambulance Services <i>(\$2,500 maximum per hospital confinement)</i> | Deductible 80% / Deductible 70% |
| Pregnancy Benefits | Deductible 80% / Deductible 70% |
| Durable Medical Equipment <i>(\$10,000 Lifetime Maximum)</i> | Deductible 80% / Deductible 70% |
| Prosthetic & Orthotic Appliances/Devices | Deductible 80% / Deductible 70% |
| Organ & Tissue Transplant Services | Deductible 80% / Deductible 70% |
| Hospice Services | Deductible 80% / Deductible 70% |
| Mental/Nervous & Substance Abuse Treatment | <i>Substance Abuse treatment has a combined lifetime maximum of \$25,000</i> |
| Inpatient Mental/Nervous & Substance Abuse Services | Deductible 50% / Deductible 50% <i>(M/N & S/A limited to 30 days each per Cal Yr)</i> |
| Outpatient Mental/Nervous & Substance Abuse Services | Ded. 50% / Ded. 50% <i>(52 visits each per Cal Yr / S/A also limited to \$80 per visit)</i> |
| Preventive/Wellness Care | |
| PAP, OBGYN Annual Exam (including related lab), Annual Physical Exam (including related x-ray & lab (\$500 maximum)), Lipid Panel Bloodwork, Bone Density Screening (one every two years if age 50 or greater), Well Baby Exam (excluding immunizations), Sigmoidoscopy (refer to your plan document for limitations), Routine Mammogram, Prostate (PSA), occult blood (colon) screening | Deductible 80% / Deductible 70% |
| Prescription Drug Benefit | |
| Pharmacy Option Copayment <i>(30 day supply) - Mandatory Mail Order For Brand Maintenance Medications After First Fill</i> | Generic - 25% of Cost / Preferred Brand - 30% of Cost / Non-Preferred Brand - 40% of Cost |
| Mail Order Option Copayment <i>(90 day supply)</i> | Generic - \$20 / Preferred Brand - \$40 / Non-Preferred Brand - \$60 |