

2010

BENEFITS COST & COVERAGE INFORMATION

A COMPARISON OF MEDICAL COVERAGE AND COST SUPPLEMENT INFORMATION



This document provides Health Care and Voluntary Benefits cost and coverage information offered to eligible BCM employees.

The following **Core Benefits** are provided to eligible employees at no cost. Additional information about these benefits is located on the BCM Intranet – Human Resources – Benefits page.

- 401(a) Retirement Plan
- Backup Family Care – Back Up Care Advantage
- Basic Accidental Death & Dismemberment Insurance (AD&D)
- Basic Life Insurance
- Bright Horizons Family Solutions
- Business Travel Accident Insurance
- Emeriti Retirement Health Solutions
- Employee Assistance Program (EAP)
- Holiday Pay
- Long Term Disability (LTD)
- Sick Pay
- Tuition Assistance
- Vacation Pay
- Wellness/Work-Life Program

QUESTIONS? Contact the HR – Benefits office:

BY PHONE: 713-798-1500

**BY E-MAIL: ask-insurance@bcm.edu
ask-retirement@bcm.edu**

IN PERSON: 2450 Holcombe, Ste. OW100, Houston, TX 77021

2010 HEALTH CARE CHOICES & COSTS

Baylor College of Medicine's Comprehensive Medical Plan offers two medical options. Both options are administered by United Healthcare (UHC) and utilize the Choice Plus network of health care providers.

BCM PREMIUM PPO OPTION

- The BCM Premium PPO Option utilizes a network of physicians at special negotiated rates. Choice Plus network provider information is available online at www.myuhc.com/groups/bcm, or you can call 1-877-BAYLOR1 (1-877-229-5671).
- You can go to any physician or medical facility for services in a PPO regardless of whether they are in or out-of-network. Your annual deductible, copayment levels, and annual out-of-pocket maximum will be affected by whether or not you use a network physician or hospital.
- There is a *deductible* if you use a PPO network facility or hospital. The deductible does *not* apply to physician office visits; however, a copay is required.
- Emergency room treatment within the network is subject to a copay, and the remaining expenses are paid at 80% after your deductible is met until you reach your out-of-pocket maximum.
- Any covered services provided in an in-network Urgent Care or Convenience Care facility will be subject to a copay - no deductible or coinsurance.
- Copays do not apply toward the deductible, including copays for prescription drugs and visits to physicians, Urgent Care facilities, or ERs.
- Coinsurance and deductible payments apply toward the out-of-pocket maximum. For example, if you are required to pay 20% of the network medical expense, that dollar amount will go toward satisfying your annual out-of-pocket maximum.
- Any service provided in a PPO network physician's office including charges for office visits, treatment, and testing will be subject to one copay (copay based on Primary Care or Specialist services). This includes allergy testing and injections, lab work, or x-rays done in the physician's office.
- If you select a physician *outside* the Choice Plus network (out-of-network), your expenses are subject to a larger deductible, and reasonable and customary limits are paid at a 60% coinsurance rate.
- When you reach your annual out-of-pocket maximum, reasonable and customary fees are paid at 100% for the remainder of the calendar year. Specific out-of-pocket limits are shown on the *2010 Medical Plan Comparison* located on the next page.

BCM VALUE EPO OPTION

- The Value EPO Option provides coverage for only those expenses provided exclusively by Choice Plus network providers. If you seek treatment from an out-of-network provider, ***no benefits will be paid***. Choice Plus network provider information is available online at www.myuhc.com/groups/bcm, or you can call 1-877-BAYLOR1 (1-877-229-5671).
- There is a *deductible* if you use a network facility or hospital. The deductible does *not* apply to physician office visits; however, a copay is required.
- Emergency room treatment within the network is subject to a copay, and the remaining expenses are paid at 80% after your deductible is met until you reach your out-of-pocket maximum.
- Any covered service provided in an in-network Urgent Care or Convenience Care facility will be subject to a copay – no deductible or coinsurance.
- The Value EPO Option covers the same in-network services as the Premium PPO Option; however, the deductibles, copays, and/or co-insurance amounts may be different. Please refer to the *2010 Medical Plan Comparison* located on the next page.

MEDICAL PLANS	YOU PAY		BCM PAYS	TOTAL MONTHLY COST
	BI-WEEKLY	MONTHLY	MONTHLY	
BCM PREMIUM PPO				
Employee Only	\$ 65.13	\$ 141.12	\$ 345.39	\$ 486.51
Employee + Spouse*	\$ 163.30	\$ 353.82	\$ 642.07	\$ 995.89
Employee + Child(ren)	\$ 155.34	\$ 336.58	\$ 543.77	\$ 880.35
Employee + Family*	\$ 242.46	\$ 525.32	\$ 919.90	\$ 1,445.22
BCM VALUE EPO				
Employee Only	\$ 20.91	\$ 45.31	\$ 409.37	\$ 454.68
Employee + Spouse*	\$ 71.33	\$ 154.55	\$ 776.19	\$ 930.74
Employee + Child(ren)	\$ 63.06	\$ 136.63	\$ 686.12	\$ 822.75
Employee + Family*	\$ 124.22	\$ 269.15	\$ 1,081.52	\$ 1,350.67

**If you are providing coverage for your domestic partner who is not a tax dependent, the portion of the premium relating to your domestic partner will be deducted on an after-tax basis and the balance of the premium will be paid on a pre-tax basis. Contact HR-Benefits at 713-798-1500 or ask-insurance@bcm.edu if you have additional questions.*

TERMS YOU NEED TO KNOW

Coinsurance – percent of expense you pay

Convenience Care facility – health care clinics located in retail stores, supermarkets, and pharmacies that treat minor illnesses and provide preventative health care services (i.e., BCM Express Care Center, CVS Minute Clinic, and Walgreens take care clinic, etc.)

Copay – fee you pay for specific services in plan

Deductible – amount you pay before the Plan begins to pay

Emergency Care – care provided due to acute life-threatening situations including excessive bleeding, chest pains, loss of consciousness

In-network – services you receive from physicians/hospitals within the network (fees have been discounted)

Newborn Care – claims relating to a healthy newborn are processed under the mother's claim. Any claim for a newborn that experiences health issues (including jaundice) will not be processed until the baby is added as your dependent within 31 days of birth

Out-of-network – services you receive from a physician or hospital outside the network (you pay retail for these services) and charges are subject to R&C

Out-of-pocket – how much you pay before the Plan begins to pay 100% of claims for the remainder of the calendar year

PCP – a primary care physician (PCP) is a medical doctor who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions (All doctors consisting of Family Practice, General Practice, Internal Medicine, and Pediatrics.)

R&C – Reasonable & Customary limit for specific service or supply

Urgent Care facility – a facility used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room

2010 MEDICAL PLAN COMPARISON

<i>SERVICES</i>	<i>BCM PREMIUM PPO</i>		<i>BCM VALUE EPO</i>
	<i>NETWORK</i>	<i>OUT-OF-NETWORK</i>	<i>NETWORK ONLY</i>
LIFETIME MAXIMUM	\$3,000,000 – no more than \$2,000,000 in any one calendar year		\$2,000,000
ANNUAL DEDUCTIBLE	\$250 per person/\$500 per family	\$700 per person/\$1,400 per family	\$500 per person/\$1,000 per family
OUT-OF-POCKET MAXIMUM	\$3,000 per person/\$6,000 per family	\$8,000 per person/\$16,000 per family	\$4,000 per person/\$8,000 per family
ALLERGY EVALUATION & TESTING	\$25 copay (in doctor's office)	60% after deductible	\$35 copay (in doctor's office)
ALLERGY AND OTHER INJECTIONS	\$15 copay in doctor's office (primary care) \$25 copay in doctor's office (specialty)	60% after deductible	\$20 copay in doctor's office (primary care) \$35 copay in doctor's office (specialty)
AMBULANCE SERVICE	80%	80%	80%
ANCILLARY SERVICES SUCH AS: • RADIOLOGY • PATHOLOGY • ANESTHESIOLOGY • LABORATORY • X-RAY	\$15 copay in doctor's office (primary care) \$25 copay in doctor's office (specialty) <i>80% after deductible if service performed in network hospital setting or ancillary facility</i>	60% after deductible	\$20 copay in doctor's office (primary care) \$35 copay in doctor's office (specialty) <i>80% after deductible if service performed in network hospital setting or ancillary facility</i>
CHEMICAL DEPENDENCY/MENTAL HEALTH – INPATIENT	80% after deductible	60% after deductible	80% after deductible
CHEMICAL DEPENDENCY/MENTAL HEALTH – OUTPATIENT	\$25 copay (specialty)	60% after deductible	\$35 copay (specialty)
CHIROPRACTIC MANIPULATION	80% after deductible	60% after deductible	80% after deductible
	<i>Limited to \$2,000 per calendar year</i>		
CONVENIENCE CARE FACILITY	\$15 copay (no deductible/coinsurance)	60% after deductible	\$20 copay (no deductible/coinsurance)
DOCTOR'S OFFICE VISIT	\$15 copay (primary care) \$25 copay (specialty)	60% after deductible	\$20 copay (primary care) \$35 copay (specialty)
DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible	80% after deductible
	<i>\$2,500 annual maximum, pre-notification over \$1,000</i>		
EMERGENCY ROOM CARE ACUTE LIFE-THREATENING SITUATIONS (EXCESSIVE BLEEDING/CHEST PAINS/LOSS OF CONSCIOUSNESS)	80% after \$100 copay and deductible <i>(Emergency care copay waived if admitted)</i>	80% after \$100 copay and deductible <i>(Emergency care copay waived if admitted)</i>	80% after \$100 copay and deductible <i>(Emergency care copay waived if admitted)</i>
INFERTILITY TESTING & TREATMENT	\$25 copay in doctor's office (specialty) 80% after deductible if not in doctor's office	60% after deductible	\$35 copay in doctor's office (specialty) 80% after deductible if not in doctor's office
	<i>Lifetime maximum \$10,000 (Prescription drugs are handled under the Prescription Drug Program and accumulate toward the lifetime maximum)</i>		
INPATIENT HOSPITAL STAY	80% after deductible	60% after deductible	80% after deductible
MATERNITY – INPATIENT	80% after deductible	60% deductible	80% after deductible
MATERNITY – OUTPATIENT	\$25 copay (specialty) – applies to initial prenatal office visit only	60% after deductible	\$35 copay (specialty) – applies to initial prenatal office visit only
NEWBORN CARE	80% after deductible	60% after deductible	80% after deductible
	<i>Charges will not be covered unless newborn is enrolled within 31 days of birth. Contact Benefits at 713-798-1500.</i>		
THERAPY: • PHYSICAL • CARDIAC • SPEECH • PULMONARY • OCCUPATIONAL	80% after deductible	60% after deductible	80% after deductible
	<i>60 visits per condition annually (limits apply)</i>		
PRESCRIPTION DRUGS	<ul style="list-style-type: none"> ▪ Short-term – 30-day supply (Retail) <ul style="list-style-type: none"> – \$ 10 copay for generic or contracted rate if less – \$ 40 copay for preferred formulary brand-name or contracted rate if less – \$ 60 copay for non-preferred formulary brand-name ▪ Mail-order – 90-day supply <ul style="list-style-type: none"> – \$ 20 copay for generic – \$ 80 copay for preferred brand-name – \$120 copay for non-preferred brand-name 	Not covered unless Caremark network pharmacy is used	<ul style="list-style-type: none"> – Short-term – 30-day supply (Retail) <ul style="list-style-type: none"> – \$ 10 copay for generic or contracted rate if less – \$ 40 copay for preferred formulary brand-name or contracted rate if less – \$ 60 copay for non-preferred formulary brand-name ▪ Mail-order – 90-day supply <ul style="list-style-type: none"> – \$ 20 copay for generic – \$ 80 copay for preferred brand-name – \$120 copay for non-preferred brand-name
	<i>Brand Name drugs covered only when prescribed and specified in writing by a physician</i>		
URGENT CARE FACILITY	\$50 copay (no deductible/coinsurance)	60% after deductible	\$50 copay (no deductible/coinsurance)
WELLNESS BENEFIT – INCLUDING BUT NOT LIMITED TO: ANNUAL PHYSICAL, WELL-CHILD EXAM (includes immunizations through age one), WELL-WOMAN EXAM, MAMMOGRAMS, PROSTATE SCREENING	100% up to \$800 maximum, then 80% of remaining expenses (not subject to deductible or copay)	100% up to \$800 maximum, then 80% of remaining R&C limits (not subject to deductible or copay)	100% up to \$400 maximum, then 80% of remaining expenses (not subject to deductible or copay)

2010 HEALTH CARE CHOICES & COSTS

DENTAL PPO PLAN

BCM's Comprehensive Medical Plan offers one dental plan administered by United Healthcare (UHC). You can choose to seek dental treatment in the UHC dental network or outside the network. A higher level of dental benefit coverage is provided when you use UHC dental network providers. Your annual deductible and copayments are affected by whether or not you use a network or out-of-network provider. Network provider information is available at www.myuhcdental.com.

SERVICE CATEGORY	NETWORK	OUT-OF-NETWORK	DESCRIPTION OF SERVICES
Annual Deductible	\$50/participant	\$100/participant	
Basic & Major Services	\$150/family	\$300/family	
Annual Maximum Benefit for Basic & Major Services	\$3,000/participant	\$2,000/participant	
PREVENTIVE SERVICES			
You Pay	0%	20%	<ul style="list-style-type: none"> ▪ Two oral exams and cleanings per year ▪ One bitewing x-rays per year ▪ Two periodontal prophylaxis per year ▪ One fluoride treatment per year ▪ One complete mouth x-rays (panoramic) every 3 years ▪ Sealants every 3 years for children under age 16
Plan Pays	100%	80%	
BASIC SERVICES			
You Pay	10%	30%	<ul style="list-style-type: none"> ▪ Emergency palliative treatment ▪ Fillings ▪ Fixed space maintainers
Plan Pays	90%	70%	
MAJOR SERVICES			
You Pay	20%	50%	<ul style="list-style-type: none"> ▪ Inlays & Onlays ▪ Crowns ▪ Bridgework ▪ Dentures
Plan Pays	80%	50%	
ORTHODONTIA (CHILDREN THROUGH AGE 18)			
You Pay	40%	50%	<ul style="list-style-type: none"> ▪ Appliances and services to correct the positioning of teeth ▪ Benefit available for children through age 18 only
Plan Pays	60%	50%	
Lifetime Maximum	\$2,500/participant	\$1,500/participant	

*Oral Surgery – includes extractions and is subject to \$5,000 lifetime maximum

DENTAL PPO COSTS

COVERAGE LEVEL	YOU PAY		BCM PAYS	TOTAL MONTHLY COST
	BI-WEEKLY	MONTHLY	MONTHLY	
Individual Only	\$ 3.32	\$ 7.20	\$ 27.44	\$ 34.64
Individual + Spouse	\$ 14.93	\$ 32.34	\$ 50.77	\$ 83.11
Individual + Child(ren)	\$ 10.66	\$ 23.10	\$ 46.15	\$ 69.25
Individual + Family	\$ 27.72	\$ 60.06	\$ 64.62	\$ 124.68

VISION CARE PLAN

The Voluntary Vision Care Program is administered by EyeMed. Vision care services are provided at Lenscrafters, Pearle Vision, Sears Optical, and Target Optical. In addition, EyeMed provides a network of thousands of optometrists, opticians, and ophthalmologists. You can seek vision care services in the network or outside the network. Provider information is available to you online at www.eyemedvisioncare.com (Network = Access).

SERVICE CATEGORY	YOUR COST	OUT-OF-NETWORK REIMBURSEMENT
Exam with dilation as necessary	\$10 Copay	Up to \$40
Contact Lens (fit & follow-up)		
▪ Standard	Paid in full; includes fit and two follow-up visits	Up to \$40
▪ Premium	10% off retail price, then apply \$55 allowance	Up to \$40
Frames	\$110 allowance; 80% over \$110	Up to \$55
▪ Standard Plastic Single Vision	\$10 Copay	Up to \$25
▪ Bifocal	\$10 Copay	Up to \$40
▪ Trifocal	\$10 Copay	Up to \$65
▪ Standard Progressive	\$10 Copay	Up to \$80
▪ Premium Progressive	\$10 copay; 80% of charge less \$120 allowance	Up to \$80
Contact lenses (materials)		
▪ Conventional	\$110 allowance; 85% of balance over \$110	Up to \$80
▪ Disposables	\$110 allowance	Up to \$80
▪ Medically necessary	Paid in full	Up to \$200
LASIK and PRK Vision Correction	15% off retail price or 5% off promotional pricing	N/A

VISION CARE COSTS

COVERAGE LEVEL	YOU PAY		BCM PAYS	TOTAL MONTHLY COST
	BI-WEEKLY	MONTHLY	MONTHLY	
Individual Only	\$ 3.81	\$ 8.25	N/A	\$ 8.25
Individual + 1 Dependent	\$ 7.23	\$ 15.67	N/A	\$ 15.67
Individual + Family	\$ 10.66	\$ 23.09	N/A	\$ 23.09

VOLUNTARY PROGRAMS CHOICES & COSTS

FLEXIBLE SPENDING ACCOUNTS (FSAs)

United Healthcare is the administrator for FSAs. FSAs are subject to Internal Revenue Service rules and regulations.

Health Care FSA

- Set money aside before federal income and FICA taxes are withheld for reimbursement of out-of-pocket health care expenses not covered by a medical, dental, and/or vision plan
- Health Care FSA maximum of \$5,000 on a pre-tax basis
- Some eligible FSA expenses include your deductible, adult or children's orthodontics, lasik surgery, copays for office visits or prescription drugs, and certain over-the-counter drugs

Dependent Care FSA

- Set money aside before federal income and FICA taxes are withheld for reimbursement of child care and elder care expenses
- Dependent Care FSA maximum of \$5,000 per family on a pre-tax basis
- To be eligible for Dependent Care FSA reimbursement, you must be dependent upon a care provider in order to go to work

FSA Consumer Account Card

- Provided to all employees who participate in an FSA
- Instant payment for qualified medical, prescription, dental, vision care, and dependent care expenses directly from your FSA account

VOLUNTARY SHORT TERM DISABILITY (STD)

- An insurance product through Unum Insurance Company
- Convenient payroll deductions
- Coverage is 60% of your weekly salary up to a maximum of \$3,000 per month
- Cost is 100% employee-paid and premium amount is based on your age
 - \$1.13 per \$10 of covered weekly salary for ages 17- 49
 - \$1.51 per \$10 of covered weekly salary for ages 50 - 79
- Premiums are not subject to pre-tax treatment and STD benefits paid are tax free
- Enrollment by telephone at 877-317-8451

VOLUNTARY GROUP LEGAL SERVICES

- Legal services at a low monthly fee for you and your eligible dependents through Hyatt Legal Plans, a MetLife Company
- Provides access to experienced attorneys to assist you by telephone or in person
- Examples of some covered services are wills, codicils, living wills, powers of attorney, living trusts, consumer protection, identity theft defense, traffic ticket dismissal, and more
- Cost is \$20 per month (\$9.23 per bi-weekly payroll deduction)
- More detailed information is available at <https://mybenefits.metlife.com/MyBenefits> (password: 100610) or by telephone at 800-423-0300

CNA LONG TERM CARE

- An insurance product – contact CNA at the phone number below for an enrollment packet that includes rates and an application
- Provides a daily benefit for persons with prolonged physical illness, disability, or cognitive disorders to help them maintain their level of functioning
- Includes daily activities (bathing, dressing, and eating; home health care; adult health care; care in a nursing home)
- Coverage choices are a maximum daily benefit for a long term facility of \$100/day, \$200/day, or \$300/day (*Evidence of Insurability may be required*)
- More detailed information and costs are available at www.ltcbenefits.com (password: Baylor) or by telephone at 877-777-9072

SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

- Supplemental AD&D insurance coverage is in addition to the Basic AD&D insurance benefit provided by BCM at no cost to you (one times your base annual salary)
 - Choices are available in increments of \$100,000 up to a maximum election of \$1,000,000
 - Coverage can be elected for yourself only or you and your eligible dependents
 - Cost is based on the principal sum of insurance in force
 - These premiums are not subject to pre-tax treatment

COVERAGE OPTION	EMPLOYEE ONLY FLAT MONTHLY RATE	EMPLOYEE + FAMILY FLAT MONTHLY RATE
\$ 100,000	\$ 2.00	\$ 3.50
200,000	4.00	7.00
300,000	6.00	10.50
400,000	8.00	14.00
500,000	10.00	17.50
600,000	12.00	21.00
700,000	14.00	24.50
800,000	16.00	28.00
900,000	18.00	31.50
1,000,000	20.00	35.00
FAMILY COVERAGE: Spouse/Domestic Partner Child or Children	WITH CHILDREN 50% of Employee Coverage \$25,000 Each Child	WITHOUT CHILDREN 60% of Employee Coverage

OPTIONAL LIFE INSURANCE CHOICES & COSTS

SUPPLEMENTAL LIFE INSURANCE

- Life insurance coverage in addition to the Basic Life insurance benefit provided by BCM at no cost to you (three times your base annual salary)
 - Choices are an additional one, two, or three times your base annual salary including applicable fee income; however, you may only increase your coverage level by one times your annual salary per year
 - Cost is based on age
 - Rates are based on monthly cost per \$1,000 of coverage with a \$500,000 maximum
 - These premiums are not subject to pre-tax treatment and may increase during the calendar year due to change in age or salary

Example: If you earn \$40,000 and are 37 years of age and you elect Supplemental Life coverage at two times your base annual salary, your amount of supplemental coverage is \$80,000 and your age factor is \$.090 per \$1,000 of coverage. Divide \$80,000 by 1,000 and multiply the result by \$.090 to calculate your monthly premium. ($\$40,000 \times 2 = \$80,000 \div 1,000 = 80 \times \$.090 = \$7.20/\text{mo.}$)

DEPENDENT LIFE INSURANCE

- Life insurance coverage for your dependents [spouse/domestic partner and/or child(ren)]
 - Spouse/Domestic Partner - \$25,000
 - Child - \$5,000 for each eligible dependent child (up to age 19 or up to age 25 if full-time student)
 - Proof of insurability may be required
 - Cost is based on your age
 - Rates are a flat monthly rate
 - These premiums are not subject to pre-tax treatment

YOUR AGE	SUPPLEMENTAL LIFE COST PER \$1,000 COVERAGE	DEPENDENT LIFE FLAT MONTHLY RATE
Less than 30	.063	\$ 3.40
30 — 34	.072	3.40
35 — 39	.090	4.32
40 — 44	.135	5.90
45 — 49	.234	7.72
50 — 54	.387	11.34
55 — 59	.630	17.69
60 — 64	.891	26.76
65 — 69	1.692	40.73
70 — 74	2.682	63.23
75 — 79	2.682	85.50
80 +	2.682	85.50