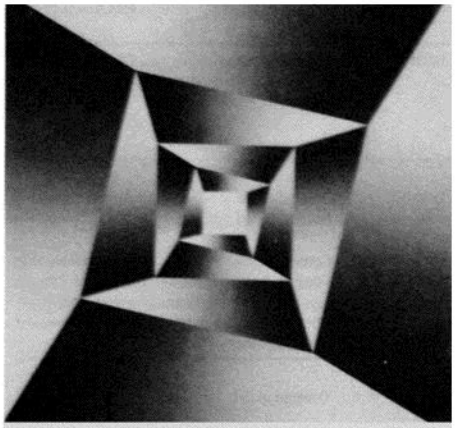

Open Enrollment: April 2-12

Open Enrollment time is here. Most of you will be receiving your Pennflex Open Enrollment package by the end of this week. An important feature of this year's Open Enrollment is the addition of a new HMO, Keystone.

The package will include: the Pennflex 1990-91 booklet highlighting the new plan year changes; the new plan year health rate sheet; an enrollment form which must be completed and returned by April 12; and, if you were hired as of July 1, 1989, a personalized Annual Benefits Statement.

Open Enrollment allows you to take a closer look at your current benefits and make changes that throughout the plan year can only be made if you experience a "life event" such as marriage, divorce, or birth of a child.

If you have been contemplating switching your health plan, reducing your life insurance, or increasing your Dependent Care Expense Account contribution, this is the time to act.

The Annual Open Enrollment Benefits Fair sponsored by the Human Resources Benefits Office will be held this year on April 3 at the Faculty Club's Alumni Hall from noon to 2 p.m. If you are unable to attend the Fair and need assistance with Open Enrollment, the Benefits Office is also sponsoring additional mini Question & Answer sessions. For further information call the Pennflex Hotline, Ext. 8-0852.

Remember, you must submit your enrollment form by April 12. If an enrollment form is not received, all of your benefits will remain the same as last year except for the Medical and Dependent Care Expense Accounts. All payroll contributions for the Health and Dependent Care Expense Accounts will cease effective July 1, 1990 if no enrollment form is received.

If you misplace your Pennflex package or if you are a new employee, in which case you will not be receiving one, you may obtain the Pennflex package at either the main Benefits Office, 3401 Walnut Street, 5th floor, or the Medical School Benefits Office, 316 Blockley Hall. In addition, you may pick up information packets regarding the various health plans at either Benefits Office or at the following campus locations:

Dental School: 1st floor, General Office
Morris Arboretum: Gates Hall
New Bolton Center: Administrative Services
Scheie Eye Institute: Patricia Vickers, Annex Building
School of Engineering: 285 Towne Building
Steinberg/Dietrich: Administrative Services, Suite 1040
Veterinary School: Dean's Office, Room 130
Veterinary Hospital: Room 2003

Also, please contact the Benefits Office at Ext. 8-0852 (Pennflex Hotline) if you have any questions about your coverages.

—Benefits Office, Human Resources

Plan	Blue Cross Plans		Health Maintenance Organizations (HMOs)
Plan Name (*Pennflex* Option)	**Comprehensive**	**Blue Cross/Blue Shield 100/Major Medical**	**Greater Atlantic Health Service**
Type of Plan	One plan covering hospitalization, medical and surgical services. Plan pays 80% of covered expenses after a $200 deductible is met ($400 per family). Maximum out-of-pocket expenses (excluding copayments for outpatient mental care) is $1,200 for individual coverage and $3,400 for family coverage. *Coverages subject to deductibles and copayments are identified by a dot (•)*	Hospitalization, medical, surgical expenses and major medical insurance. Generally pays for medically necessary treatment in or by Blue Cross-approved providers	A group network model HMO comprised of medical professionals providing care in a group office setting, or individual physicians practicing in their offices.
Service Area and Emergencies	Guaranteed benefits in any approved hospital—services of any physician up to the "Usual and Customary Rate" (UCR) charged for that treatment.	Guaranteed benefits in any approved hospital—services of any physician up to UCR . . . BC/BS	Five Delaware Valley counties and Burlington, Camden and Gloucester Counties. Emergency treatment anywhere covered in full after $25 copay. Copay waived if admitted to hospital. Primary care physician must be notified within 24–48 hours of treatment, otherwise expenses not covered.
Inpatient Hospital	• Unlimited days, semi-private room.	Up to 120 days, semi-private room with $5/day copayment for first ten days . . . BC	No maximum limit.
Outpatient Treatment	Covered in full at hospital for accident or medical emergency. Home health care covered in full. No deductibles or copayment required.	Covered at hospital within 72 hours of accident or medical emergency—$5 copayment Hospital Charges . . . BC Physician charges . . . BS	Covered in full.
Physician Visits:			
Hospital	• Covered up to UCR.	Covered up to UCR . . . BS	Covered in full.
Office	• Covered up to UCR.	80% covered after $100 annual deductible . . . MM	Covered in full.
Home	• Covered up to UCR. • Balances over UCR not covered.	21 visits covered if applicant subscriber is totally disabled, $25 deductible . . . BS	Covered in full. Physical therapy is limited to a non-renewable maximum of up to 20 visits within a sixty-day period, per occurrence.
Physician Care:			
Surgery	• Covered up to UCR for inpatient. Covered at 100% UCR for outpatient.	Covered up to UCR . . . BS	Covered in full.
Anesthesia	• Covered up to UCR.	Covered up to UCR . . . BS	Covered in full.
Consultants	• Covered up to UCR.	Covered up to UCR . . . BS	Covered in full.
Laboratory, X-rays and Tests	Covered in full up to UCR for diagnostic purposes only. No deductibles or copayment required.	Covered in full for most diagnostic purposes only. Hospital charges $5 copay . . . BC Physician charges covered up to UCR . . . BS	Covered in full.
Maternity	• Covered up to UCR.	Covered up to UCR . . . BS	Covered in full.
Preventive Medicine, Physical Exams	Not covered.	Not covered.	Covered in full. Immunizations are covered. Medications requiring prescription are not covered.
Eye, Ear Exams	Not covered.	Not covered.	Covered (including refractions). Discount on glasses or contacts of $20.00 or 20% at participating optical shops. Hearing aids not covered.
Second Surgical Opinions	Covered at 100% UCR for listed procedures. No deductibles or copayment required.	Covered at 100% UCR . . . BS	Covered in full but not required.
Mental Inpatient: Hospital and Physician	Coverage for 30 days per benefit period. Maximum coverage limited to $100,000 lifetime, including outpatient care.	Coverage for 30 days. Renewed after 365 days from discharge. Maximum coverage limited to $25,000 lifetime, including outpatient care . . . BC/BS/MM	30 days per benefit year.
Mental Outpatient: Physician	50% UCR, up to $1,250 per year. Maximum coverage limited to $100,000 lifetime, including inpatient care.	50% UCR up to $2,000 annual maximum. Lifetime maximum limited to $25,000, including inpatient care . . . MM	20 visits per year. 1–2 visits. Covered in full. 3–10 visits. $10 copay per visit. 11–20 visits. $25 copay per visit. Additional visits. A standard fee.
Prescriptions	Covered at 80% UCR after deductible.	Covered at 80% UCR after $100 deductible . . . MM	N/A
Dental Care	N/A	N/A	N/A

(Note: "UCR" means the "Usual and Customary Rate" for a particular medical service in a given geographic area. Note: BC=Blue Cross; BS=Blue Shield; MM=Major Medical. These abbreviations indicate under which category, in most instances, the benefits are covered and the type of Blue Cross form needed for claim submission. Under the Comprehensive Plan, the claim form is the same for all benefits.)

Health Maintenance Organizations (HMOs)

U.S. Healthcare HMO of Pennsylvania/New Jersey	Delaware Valley HMO	Health Insurance Plan of N.J.	Keystone Health Plan East Pennsylvania Blue Shield's HMO
An individual practice association HMO comprised of physicians who provide care through their own offices and affiliated hospitals.	An individual practice association HMO comprised of physicians who provide care through their own offices and affiliated hospitals.	A group practice HMO comprised of medical professionals providing care from a center or from a network of private physicians.	An individual practice association HMO comprised of physicians who provide care through their own offices and affiliated hospitals.
Five Delaware Valley counties and three Lehigh Valley counties in PA, all counties in New Jersey and Delaware. Emergency treatment anywhere covered in full after $15 copay. Primary care physician must be notified within 24-48 hours of treatment, otherwise expenses not covered.	5 Delaware Valley counties in PA, plus state of Delaware. Emergency treatment anywhere covered in full after $15 copay. Copay waived if admitted to hospital. Primary care physician must be notified within 24-48 hours of treatment, otherwise expenses not covered	Burlington, Camden and Gloucester counties. Emergency treatment anywhere covered in full. Primary care physician must be notified within 24-48 hours of treatment, otherwise expenses not covered.	Philadelphia, Bucks, Chester, Delaware & Montgomery Counties. Emergency treatment covered in full with a $15.00 copayment. Fee is waived if admitted to hospital. Primary care physician must be notified within 24-48 hours of treatment, otherwise expenses not covered.
No maximum limit.	No maximum limit.	No maximum limit.	No maximum limit.
Covered in full. $5 copayment for physician services in emergency cases.	Covered in full.	Covered in full.	Covered in full.
Covered in full. Covered $2 copay per visit. Covered $5 copay per visit. Physical therapy is limited to 60 days, short-term basis only, per occurrence.	Covered in full. Covered $3 copay per visit. Covered $5 copay per visit. Physical therapy is limited to 60 days, short-term basis only, per occurrence.	Covered in full. Covered in full. Covered in full. Physical therapy is limited to 60 days, short-term basis only, per occurrence.	Covered in full. Covered with a $2 copayment. Covered with a $5 copayment. Physical therapy is limited to 60 days short-term basis only per occurrence.
Covered in full.	Covered in full.	Covered in full.	Covered in full.
Covered in full. Covered in full.	Covered in full. Covered in full.	Covered in full. Covered in full.	Covered in full. Covered in full.
Covered in full.	Covered in full.	Covered in full.	Covered in full.
Covered in full.	Covered in full.	Covered in full.	Covered in full.
Covered in full. Immunizations are covered. Medications requiring prescription are not covered.	Covered in full.	Covered in full.	Covered in full. Immunizations are covered. Medications requiring prescription are not covered.
Covered (including refractions). Hearing aids not covered. $35 allowed for contacts or eyeglasses every two years.	Covered (including refractions) for all ages. Hearing aids not covered. $50 allowed for eyeglasses or contacts every two years.	Covered-including refractions ($5 copay) every two years. Hearing aids and glasses not covered.	Eye examinations are covered in full once every two years. Members are reimbursed $35 once every two years toward the purchase of eyeglasses or contact lenses. Ear exams are covered in full.
Covered in full if requested.	Covered in full if requested.	Covered in full but not required.	Covered in full.
35 days per year.	30 days per year.	30 days per year.	30 inpatient days combined with drug rehabilitation.
20 visits per year. Two visits no copay, next three-ten $10 copay. Next ten $25 copay.	20 visits per year, one-three no copay, four-ten 25% copay, 11-20 50% copay.	20 visits per year, covered in full.	Up to 20 outpatient visits covered. First two visits covered in full. Remaining 18 visits covered with a $25 copayment, or 50% of allowable charges, whichever is less.
N/A	$50 deductible per person, $500 maximum per family.	80% reimbursement after $100 deductible, per person.	N/A
Preventive dental for children under 12. Two visits per year for cleaning, fluoride, and exam.	Office visits, fluoride treatments, are some services covered in full. Other services with copayment.	Annual dental exam, cleaning, X-rays, and fluoride treatment covered in full. 25% dental discount on other dental services.	Pediatric preventive dental coverage. Two visits per year for cleaning, scaling, and fluoride treatments.

(Note: The plan year for all medical and dental plans is July 1 through June 30.)

Group Medical Insurance and Health Maintenance Programs

Premium Rates for Subscribers and Dependents
Effective July 1, 1990 through June 30, 1991

	Comp.	BC/BS 100 Maj. Med.	Greater Atlantic	HMO PA	HMO NJ	Del. Valley HMO	HIP of NJ	Keystone
TOTAL RATE—SINGLE	$ 90.55	$127.63	$ 90.63	$106.72	$133.80	$133.72	$120.88	$ 94.05
University Contribution—Monthly	89.63	89.63	89.63	89.63	89.63	89.63	89.63	89.63
Subscriber Contribution—Monthly	.92	38.00	1.00	17.09	44.17	44.09	31.25	4.42
Subscriber Contribution—Weekly	.21	8.77	.23	3.94	10.19	10.17	7.21	1.02
TOTAL RATE—FAMILY	240.23	330.15	247.40	293.32	353.15	344.73	323.40	255.23
University Contribution—Monthly	224.90	224.90	224.90	224.90	224.90	224.90	224.90	224.90
Subscriber Contribution—Monthly	15.33	105.25	22.50	68.42	128.25	119.83	98.50	30.33
Subscriber Contribution—Weekly	3.54	24.29	5.19	15.79	29.60	27.65	22.73	7.00

Dental Assistance Program Comparison and Rates 1990-91

Type of Service or Treatment	Percentage Paid	
	PFPP	Prudential
Diagnostics (exams, x-rays)	100%	100%
Preventive (teeth cleaning, fluoride)	100%	2 visits/plan year reimbursements limited
Restorative (fillings)	100%	90%
Oral Surgery (extractions)	100%	100%
	(**Note:** Some oral surgery may be covered under your medical plan)	
Endodontics (root canal therapy)	90%	80%
Periodontics (gum disorders)	90%	80%
Prosthodontics (bridges, false teeth)	60%	50%
Crowns and Restorations (gold crowns, restorations, caps)	60%	50%
Orthodontics (teeth straightening for children under age 19 only)	60%	50% up to $1,000 lifetime maximum per person

Monthly Premium Rates
Effective July 1, 1990 through June 30, 1991

	Prudential Dental	Penn Faculty Practice Plan
Total Rate—Single	$20.29	$21.55
University Contribution—Monthly	20.29	21.55
Subscriber Contribution—Monthly	0.00	0.00
Subscriber Contribution—Weekly	0.00	0.00
Total Rate—Family	62.95	61.95
University Contribution—Monthly	35.70	35.70
Subscriber Contribution—Monthly	27.25	26.25
Subscriber Contribution—Weekly	6.29	6.06