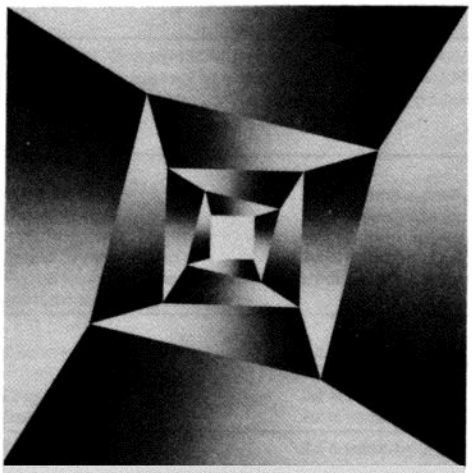

Open Enrollment: April 1-12

Open Enrollment time is here. Most of you will be receiving your Pennflex Open Enrollment package by the end of this week.

The package will include: the Pennflex 1991-92 booklet highlighting the new plan year changes; the new plan year health rate sheet; a Personal Report, and a personalized enrollment form which must be completed and returned by April 12; and, if you were hired as of July 1, 1990, a personalized Annual Benefits Statement.

Open Enrollment provides an opportunity to take a closer look at your current benefits and make any necessary changes.

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

The Annual Open Enrollment Benefits Fair sponsored by Human Resources/Benefits will be held this year on April 2 at the Faculty Club 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 Health and Dependent Care Pre-tax Expense Accounts. All payroll contributions for the Health and Dependent Care Expense Accounts will cease effective July 1, 1991 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 a 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: 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.

—Human Resources/Benefits

Plan	Blue Cross Plans		Health Maintenance Organizations (HMOs)
Plan Name (*Pennflex* Option)	**Comprehensive (1)**	**Blue Cross/Blue Shield 100/Major Medical (2)**	**Greater Atlantic Health Service (3)**
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 if you use participating Blue Shield doctors. *Coverages subject to deductibles and copayments are identified by a star (*).* Balances over UCR not covered.	Hospitalization, medical, surgical expenses and major medical insurance. Generally pays for medically necessary treatment in or by Blue Cross/Blue Shield-approved providers. Balances over UCR may be forwarded to Major Medical for consideration.	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 $200 annual deductible . . . MM	Covered in full.
Home	* Covered up to UCR.	21 visits covered if applicant subscriber is unable to work on the date of service, $25 deductible . . . BS	Covered in full. Physical therapy up to 20 visits per plan year.
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.	Outpatient hospital charges covered in full for most diagnostic purposes only, after $5 copay . . . BC Non-hospital charges covered up to UCR . . . BS 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	Routine examinations are not covered.	Routine examinations are 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 plan year. Covered at 80% UCR. 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	Up to 30 days per plan year with plan approval.
Mental Outpatient: Physician	* 50% UCR, up to $1,250 per plan year. Services must be rendered by a licensed physician or psychologist. Maximum coverage limited to $10,000 lifetime for outpatient treatment.	50% UCR up to $2,000 per plan year. Services must be rendered by a licensed physician or psychologist. 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.
Drug and Alcohol Treatment	The benefits provided under all the plans comply with Pennsylvania State Law; however, there are variations to the levels of benefits provided under each plan. Refer to Plan Booklets for specific detailed information. Plan Booklets can be obtained from the Benefits Office.		
Prescriptions	* Covered at 80% UCR.	Covered at 80% UCR after $200 deductible . . . MM	10% discount at participating pharmacies.
Dental Care	N/A	N/A	Annual routine dental exam and cleaning —$20 copay. Up to 20% discount on established fees for all other services.

(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 (5) / (6)	Delaware Valley HMO (7)	Health Insurance Plan of N.J. (8)	Keystone Health Plan East Pennsylvania Blue Shield's HMO (9)
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 and $15 copayment for hospital services in emergency cases.	Covered in full. $3 copayment for physician services and $15 for hospital services in emergency cases.	Covered in full. $2 copayment for physician services in emergency cases.	Covered in full. $2 copayment for physician and $15 for hospital services in emergency cases.
Covered in full. Covered $2 copay per visit.	Covered in full. Covered $3 copay per visit.	Covered in full. Covered in full.	Covered in full. Covered with a $2 copayment.
Covered $5 copay per visit. Physical therapy is limited to 60 days, short-term basis only, per occurrence.	Covered $5 copay per visit. Physical therapy is limited to 60 days, short-term basis only, per occurrence.	Covered in full. Physical therapy is limited to 60 days, short-term basis only, per occurrence.	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.
30 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 visits $10 copay. Next ten visits $25 copay.	20 visits per year, one-three no copay, four-ten visits 25% copay, eleven-twenty-five visits 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.

The benefits provided under all the plans comply with Pennsylvania State Law; however, there are variations to the levels of benefits provided under each plan. Refer to Plan Booklets for specific detailed information. Plan Booklets can be obtained from the Benefits Office.

N/A	$50 deductible per person, $500 maximum per person.	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.	Preventive dental coverage. Two visits per year for cleaning, scaling, and fluoride treatments.

(Note: With the exception of the Blue Cross/Blue Shield Plan 100/Major Medical Plan (Option 2), all medical and dental plans are administered on a July 1st plan year basis. Under Option 2 the Blue Cross and Blue Shield categories are administered on a calendar year basis and the Major Medical category on a July 1st plan year basis.)

Medical Plan Rates

Effective July 1, 1991 through June 30, 1992

	BC/BS 100 Comp.	BC/BS 100 Maj. Med.	Greater Atlantic	HMO PA	HMO NJ	Del.Valley HMO	HIP of NJ	Keystone
Total Rate—Single	$102.00	$145.08	$102.50	$120.83	$150.91	$134.58	$141.92	$114.83
University Contribution—Monthly	101.50	101.50	101.50	101.50	101.50	101.50	101.50	101.50
Subscriber Contribution—Monthly	.50	43.58	1.00	19.33	49.41	33.08	40.42	13.33
Subscriber Contribution—Weekly	.12	10.06	.23	4.46	11.40	7.63	9.33	3.08
Total Rate—Family	264.24	373.07	290.15	316.49	396.57	330.57	359.15	282.90
University Contribution—Monthly	253.66	253.66	253.66	253.66	253.66	253.66	253.66	253.66
Subscriber Contribution—Monthly	10.58	119.41	36.49	62.83	142.91	76.91	105.49	29.24
Subscriber Contribution—Weekly	2.44	27.55	8.42	14.50	32.98	17.75	24.35	6.75

Dental Assistance Plan Comparison and Rates 1991-92

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 are 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, 1991 through June 30, 1992

	Prudential	Penn Faculty Practice Plan
Total Rate—Single	$20.90	$23.38
University Contribution—Monthly	20.90	23.38
Subscriber Contribution—Monthly	0.00	0.00
Subscriber Contribution—Weekly	0.00	0.00
Total Rate—Family	64.84	64.84
University Contribution—Monthly	37.59	37.59
Subscriber Contribution—Monthly	27.25	27.25
Subscriber Contribution—Weekly	6.29	6.29