



2004-05 Survey of College and University Benefits Benefits I: Employee Health Care

WORKSHEETS

Once you have completed these worksheets, please enter your data in SurveysOnLine at <https://surveysonline.cupahr.org/>.

INTRODUCTION

This survey collects data on the Health Care Benefits offered by your institution or system to your **active faculty and staff employees**. The purpose of the survey is to provide information that will allow institutions to benchmark representative practices.

COMBINED PLANS THAT INCLUDE RETIREES

Report retiree health care benefits in this survey **if**, and only if, they are part of "**combined**" health care plans that include both active employees and retirees. If your institution has separate health care plans for retirees, these data should be reported in the retiree health care surveys, now also collecting data.

QUESTIONS OR PROBLEMS

If you have questions or problems regarding this survey, the primary contact is Ray Sizemore, CUPA-HR's Director of Research. He may be reached at rsizemore@cupahr.org or at 865-862-2838. The secondary contact for the survey is CUPA-HR's senior research associate, Maria Rodriguez-Calcagno. Maria may be reached at mrodriguez@cupahr.org or at 865-862-2840.

Please use email whenever possible, rather than the telephone. This is very important because we will need to forward technical questions about benefits to our benefits consultant. Using email also keeps us from being overwhelmed, as there are many of you and only two of us.

SURVEY CHANGES FOR THIS YEAR

The survey has been revised significantly in response to feedback received on last year's survey. We have simplified the survey, tried to ensure that appropriate response options are available for each question, and added a comments box at the end of each section. We also made a draft of the survey available to last year's respondents in January for comment. Although this doesn't mean that every question will have the response options that you need, hopefully most will.

WHAT DATA TO REPORT

- Report data for your institution or system, as appropriate. **Important:** Please note that in order to answer for your system as a whole, benefits must be the same across all entities within the system.
- Report benefits plan information as of January 1st of the 2004-05 academic year.
- Report faculty and staff employee counts as of January 1st of the 2004-05 academic year, and student enrollment as reported for Fall, 2004-05.
- Report Operating Budget and other financial data for your 2004-05 fiscal year.

GUIDELINES

- If you have different benefit plans within your institution, report on the plan that you believe is the **most representative** of the coverage offered to your employees.
- If your institution provides a flexible benefit program, please answer the survey questions as they pertain to your **core program**.
- Please answer all survey questions as they apply to your **full-time, non-temporary faculty and staff**, *unless otherwise instructed*. Student workers are not to be included.

CONFIDENTIALITY GUARANTEED

Complete confidentiality of each institution's data is guaranteed. Confidential data about your institution will be released only in aggregated form. For a complete statement of CUPA-HR policy regarding use of survey data, click the **Privacy Policy** link at the bottom right corner of this page.

(C) Copyright 2005 by the College and University Professional Association for Human Resources (CUPA-HR). This questionnaire is protected by copyright and may be reproduced only for the purpose of submitting data to CUPA-HR or with prior written permission of CUPA-HR.

INSTITUTIONAL BASICS

A. Expenditures, Enrollment, Staffing

This section needs to be completed only once per year by your institution and is used by all surveys— including the salary surveys which precede this survey. If someone else has entered data, please review and answer any remaining questions. If you disagree with any existing entries, please do not edit them until you have first contacted Ray Sizemore, CUPA-HR Director of Research and Information Systems.

Report information as of January 1st of the 2004-05 academic year. Error messages suggesting a minimum or maximum value are provided as an aid only. You can over-ride the message by pressing the "Enter" key.

1. Structure Reporting For

Please select the type of entity for which you are reporting data. Your options:

- Single Unit Institution.** Institution that is not part of a college or university system.
- Institution within a College or University System.** Associated with one or more other colleges or universities in a group usually headed by a main campus or system office. Has its own administration, full program of study (not just courses), and a unique FICE Code assigned by the Department of Education.
- System Office.** The administrative office that oversees a group of institutions (system) usually comprised of a main campus and several individual campuses. The System Office does not offer courses or programs of study.
- System Summary.** Select this option if you wish to report data in the **aggregate** for all colleges and universities within your system.

IMPORTANT: If you want to select this option, but the words *System Summary is not part of* your institution's name at the top of the survey page (e.g. Demonstration University System Summary), please contact Ray Sizemore at 865-862-2838.

In order to complete the **Benefits Survey** for your system as a whole, benefits must be the same across all institutions within the system.

NOTE: For the remaining questions, if you are reporting data for a system office or system summary, please supply system-wide figures. Otherwise, supply individual institution figures.

2. Financial Data

Please provide the following data for your 2004-05 fiscal year.

- a. **Total Operating Budget:** Enter the dollar value of your institution's 2004-05 total operating budget for educational and general operations and auxiliary enterprises. It **includes** research funds and *funded* student aid. It does **not include** unfunded student aid (discounts) or capital funds. Ask your comptroller for this number. Budget is a required field.
- b. **Total Endowment:** The total amount of your institution's endowment.
- c. **Composite Fringe Rate Charged to Grants:** The total cost of benefits expressed as a % of payroll for employees who are eligible for benefits.

3. Student Enrollment

Report student enrollment for **fall of the 2004-05 academic year**.

You must supply FTE enrollment figures by one of the three methods described below, which are listed in descending order of preference:

- If you can answer rows a, b and c, do so. Then **hit the "Calculate" button** below the grid and row d FTE figures will be derived for you as follows: Number of Full-Time Students + (Fall Part-Time Credit Hours divided by 15 for undergraduates, by 12 for graduates).
- If you are unable to provide row c amounts, please complete just rows a and b, leave row c blank, and then **hit the "Calculate" button**. FTE will be derived as: Number of Full-Time Students + 1/3 Number of Part-Time Students.
- If you are unable to provide amounts for at least rows a and b, please just enter your FTE figures directly in row d and leave rows a-c blank. **Don't hit the "Calculate" button.**

	Undergraduate Students	Graduate Students	Total All Students
a. Number of Full-Time Students			Do Not Enter Totals. SurveysOnline Will Calculate These Automatically.
b. Number of Part-Time Students			
c. Total Number of Fall Credit Hours Taken by Part-Time Students			
d. Full-Time Equivalent (FTE) Total Enrollment			

4. Faculty Size

Please report full-time equivalent (FTE) faculty figures for **fall of the 2004-05 academic year**. Include **all** full-time and part-time faculty.

There are two alternate ways to provide an FTE figure for faculty; the first is preferred:

- If you are able to answer rows a-d completely, Faculty FTE will be derived automatically when you **hit the "Calculate" button** below the grid as: Number of Full-Time Faculty + (Total Number of Fall Course Hours Taught by Part-Time Faculty Only / Standard Full-Time Teaching Load in Course Hours).
- If you are unable to supply amounts for some or all of rows a-d, please just enter the FTE figure directly into row e and leave rows a-d blank.

	Faculty
a. Number of Full-Time Faculty	
b. Standard Full-Time Teaching Load in Course Hours (e.g. 15)	
c. Number of Part-Time Faculty	
d. Total Number of Fall Course Hours Taught by Part-Time Faculty Only	
e. Full-Time Equivalent Faculty	

5. Collective Bargaining

Are your faculty or staff represented by a union for purposes of collective bargaining?

	Yes	No
a. Faculty		
b. Staff		

B. Health Care Benefits for Employees

Report information as of January 1st of the 2004-05 academic year.

1. What is the starting month of your Health Plan Year? _____
2. Is there a waiting period before new employees qualify for full health care coverage?
 - No waiting period
 - Waiting period for all new employees
 - Waiting period for new employees with no or lapsed insurance
 - Waiting period for new employees with a pre-existing condition
 - Waiting period for new employees with no insurance or a pre-existing condition

3. If there is a waiting period, how long is it? Report number of days.

All New Employees	New Employees With No Insurance and/or Pre-Existing Condition

4. Does your institution offer health care benefits for retirees?
 - Yes
 - No
5. Do you offer one or more institution-funded Health Reimbursement Accounts (HRA) or Health Savings Accounts (HSA)?
 - Yes – HRA only
 - Yes – HSA only
 - Yes – Both
 - No – don't offer either

6. Are full-time employees allowed to opt out of your health-related benefit plans? If yes, are they reimbursed in part or in full?

	Allowed to Opt Out of Plan?		Reimbursed in part or in full for Opting Out?	
	Yes	No	Yes	No
a. Health care insurance				
b. Prescription drugs insurance				
c. Dental insurance				
d. Vision Insurance				

7. Is health care coverage available for the following dependents of employees?

	Yes	No
1. Spouse		
2. Domestic partner		
3. Children under 19 years of age		
4. Children 19 or older that are not students		
5. Children 19 or older that are full-time students		
6. Children 19 or older that are part-time students		
7. Adopted children		
8. Children for whom employee is the legal guardian		
9. Foster children		

8. Is the employee payroll deduction for health care insurance made on a pre-tax basis according to IRS Sec. 125?
 - Yes
 - No

9. Does your institution pay the health care premiums for employees that are laid off **or** on an approved leave of absence?
- Yes – for laid off only
 - Yes – for leave of absence only
 - Yes – for both laid off and leave of absence
 - No

10. Coordination of Health Plan Benefits

- a. Which rule is used by your health care plans?
 - Birthday rule
 - First date of insurance coverage rule
- b. Do your health care plans have a claims subrogation clause?
 - Yes
 - No

11. Health Care Plan Bundling

- a. Can employees selectively choose a combination of health, life, dental, and vision coverage?
 - Yes – option to purchase one plan without the others
 - Yes – option to purchase one plan only for dependents
 - No – mandatory participation in bundled plans
- b. Do you have a Mental/Nervous carve out plan?
 - Yes
 - No

12. Which of the following benefits are provided to full-time and part-time employees?

	Full-Time Active Employees		PT Employees Half Time or Greater		PT Employees Less Than Half Time	
	Yes	No	Yes	No	Yes	No
a. Major Medical Plan						
b. Traditional Hospitalization Plan with Major Medical						
c. HMO/EPO Plan						
d. Preferred Provider Organization (PPO) Plan						
e. Point of Service (POS) Plan						
f. Prescription drug benefits						
g. Dental benefits						
h. Vision benefits						
i. Flexible Spending Account (FSA)						
j. Employee Assistance Program (EAP)						
k. Basic Life Insurance benefits						
l. Short-term disability						
m. Long-term disability						
n. Retirement benefits						
o. Vacation leave						
p. Sick leave						
q. Tuition Support						

13. How is each of the employee health care plans funded? Select one. **Note:** If you offer more than one option for a plan type, respond for plan with largest enrollment.

	Plan Type Not Available	State Employee Plan	Self-Funded System Level Plan	Self-funded Institution Based Plan	Purchased System Level Plan	Purchased Institution Based Plan
a. Major Medical Plan						
b. Traditional Hospitalization Plan with Major Medical						
c. HMO/EPO Plan						
d. Preferred Provider Organization (PPO) Plan						
e. Point of Service (POS) Plan						
f. Stand-Alone Drug Plan						
g. Stand-Alone Dental Plan						
h. Stand-Alone Vision Plan						

14. How many different plans do you offer for each of the following plan types? Enter the number or 0 if none.

	# of Plans Offered of Each Plan Type
a. Major Medical Plan	
b. Traditional Hospitalization Plan with Major Medical	
c. HMO/EPO Plan	
d. Preferred Provider Organization (PPO) Plan	
e. Point of Service (POS) Plan	
f. Stand-Alone Drug Plan	
g. Stand-Alone Dental Plan	
h. Stand-Alone Vision Plan	

15. How often does your institution seek bids for the different employee health care plans? If you have "no set schedule," enter 0.

	Every "x" Years
a. Major Medical Plan	
b. Traditional Hospitalization Plan with Major Medical	
c. HMO/EPO Plan	
d. Preferred Provider Organization (PPO) Plan	
e. Point of Service (POS) Plan	
f. Stand-Alone Prescription Drug Plan	
g. Stand-Alone Dental Plan	
h. Stand-Alone Vision Plan	

16. Are either of the following employee plans administered by third-party (TPA)?

	Yes	No	Not offered
a. Major Medical Plan			
b. Traditional Hospitalization Plan with Major Medical			

17. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!

C. FSA, EAP & Domestic Partner Benefits

Report information as of January 1st of the 2004-05 academic year.

FLEXIBLE SPENDING ACCOUNTS

1. Does your institution offer a Flexible Spending Account (FSA)? If you answer **No**, skip ahead to question 4.
 - Yes
 - No
2. Who contributes to the FSA?
 - Employee only
 - Institution only
 - Both employee and institution
3. For what purposes can the FSA be used?
 - Medical care assistance only
 - Dependent care assistance only
 - Both medical care and dependent care assistance

EMPLOYEE ASSISTANCE PROGRAM (EAP)

4. Does your institution offer an Employee Assistance Program (EAP)? If you answer **No**, skip ahead to question 7.
 - Yes
 - No

5. Is each of the following a service provider for the EAP?

	Yes	No
a. Campus organization(s)		
b. Health care vendor		
c. Insurance carrier		
d. Other vendor(s)		

6. Are the following types of support available as part of the EAP?

	Yes	No
a. Job-site intervention		
b. Counselors on campus		
c. Counselors off campus		
d. Off-hour services		
e. Services via toll-free number		
f. Services via the internet		
g. Access to services on employer time		
h. Licensed clinical social workers		
i. Psychologists		
j. Psychiatrists		

DOMESTIC PARTNER BENEFITS

7. Does your institution offer Domestic Partner Benefits? If you answer **No**, go to the end of section and Save.
- Yes
 - No

8. Institutional Policies

- a. Does your institution require formal certification of the domestic partnership?
- b. Does your institution impose limitations on changing the designation of domestic partners?
- c. Do eligible employees who opt out of domestic partner benefits receive an annual reimbursement?

	Yes		No

9. Are the following eligible for domestic partner benefits?

- a. Opposite sex partners
- b. Same sex partners
- c. Children of domestic partners

	Yes		No

10. Are domestic partners and their children eligible for the same benefits as spouses and their children?

- a. Domestic partners
- b. Children of domestic partners

	Same		Fewer

11. Please check the following benefits that are available to spouses and their children but **ARE NOT** available to domestic partners and their children.

- a. Health care insurance
- b. Prescription drugs insurance
- c. Dental insurance
- d. Vision Insurance
- e. Employee Assistance Program
- f. Life Insurance
- g. Tuition reimbursement
- h. Use of campus facilities / programs

	Not Available to Domestic Partners		Not Available to Children of Domestic Partners

12. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!

HEALTH CARE PLANS: EMPLOYEE/COMBINED PLANS

Sections D – K of the actual survey cover eight different types of health care plans. You only need to open the sections that you are going to answer. If you **are not** going to enter data for a given plan, you don't need to open the section. The last question of each section is for comments.

Pages 9 – 14 can be used to record information for Major Medical, Traditional, and HMO/EPO Plans. Copy these pages if you are going to provide data for more than one of these plan types.

Pages 15 – 20 can be used to record information for PPO and POS Plans. Copy these pages if you are going to provide data for more than one of these plan types.

Pages 21 – 26 can be used to record information for Stand-Alone Drug, Dental and Vision Plans.

Very Important: If your institution offers multiple versions of a plan, please report the one with the highest enrollment. For example, if you offer 3 PPO plans, report the one with the highest number of lives enrolled.

To help you keep track - space is provided at the top right side of the page for recording the name of the plan for which you are entering data.

Major Medical, Traditional, and HMO/EPO Plans

Indicate which medical plan you are reporting. If your institution offers multiple versions of a plan (e.g. 2 HMO plans), report the **one with the highest enrollment**. Make copies if you are going to provide data for more than one of these three plans.

Major Medical Plan Section D of survey online

Major Medical Plans typically pay a portion of expenses for illness and injury after deductibles, co-payments, or coinsurance have been satisfied. Participants may choose providers without restrictions. **Major Medical Plans differ from Traditional Hospitalization Plans, which you report on in Section E.**

Traditional Plan Section E of survey online

Traditional Hospitalization Plans provide **FULL** coverage for inpatient hospital, surgical, and medical care, but also have a major medical component that pays a portion of expenses for illnesses and injuries after satisfying deductibles co-payments, or coinsurance. Participants may choose providers without restriction.

HMO/EPO Plan Section F of survey online

Health Maintenance Organization (HMO) and Exclusive Provider Organization (EPO) health plans provide a full range of benefits and services within a certain geographic area. The provider is usually located in one facility/clinic or is connected by an administrative component. No benefits are available if the participant uses out-of-network providers.

1. Is this health care plan a **combined plan** that includes both active employees **and** retirees?
 Yes
 No

2. How many **Lives** (including dependents) are currently enrolled in this health care plan?
Active Employees or Combined Plan

--

3. What is the **budgeted or projected total cost** of this health care plan during the current plan year? Enter whole dollars. You may need to ask your controller.

Active Employees or Combined Plan

Institution's Total Cost	Employee Total Cost

4. Did the **cost of coverage** for this health care plan change this year over last?
 • Enter 0 if it stayed the same.
 • Enter a % **increase** in cost as a positive number to one decimal place (ex. 4.3).
 • Enter a % **decrease** in cost as a negative number to one decimal place (ex. -5.2).

	% increase or decrease
a. Institutional costs	
b. Employee costs	

5. Does this health care plan also cover the following?

	Yes	No
a. Prescription Drug Insurance		
b. Dental Insurance		
c. Vision Insurance		

6. Does this health care plan include an institution-funded Health Reimbursement Account (**HRA**) or Health Savings Account (**HSA**)?

- Yes - HRA
 Yes - HSA
 Yes - Both HRA and HSA
 No

7. Does this health care plan require **pre-certification** for the following?

	Yes	No	Not a Benefit
a. Inpatient hospital admission			
b. Outpatient mental health/ substance abuse care			
c. Inpatient mental health/ substance abuse care			
d. Home health care			
e. Home infusion therapy			
f. Hospice care			
g. Organ & tissue transplants			
h. Physical therapy			
i. Speech, occupational, vision, & hearing therapy			
j. Outpatient private nursing			
k. Skilled nursing facility admission			
l. Chiropractic services			
m. Does this plan require notification of emergency services within a specified time?			

8. What are the monthly contribution rates for this health care plan in effect as of January 1 of 2004-05 Academic Year? Use only the coverage categories that are appropriate. **If applicable, report HRA/HSA contribution separately;** leave blank otherwise. If your institution uses a tiered system based on salary, use the most representative rate, typically the one associated with the highest enrollment.

Active Employees/ Combined Plan	Employee's monthly \$ contribution to Plan	Institution's monthly \$ contribution to Plan	Institution's monthly \$ contribution to HRA/HSA
a. Employee only			
b. Employee + 1			
c. Employee + Spouse			
d. Employee + Child(ren)			
e. Family			

9. Medical Deductibles, Coinsurance, and Maximums - If 0 or *Unlimited*, enter 0.

	Active Employees/ Combined Plan \$
a. Annual deductible - \$ per individual	
b. Annual deductible - \$ per family	
c. % paid by plan after deductible met	
d. Annual out-of-pocket maximum - \$ per individual	
e. Annual out-of-pocket maximum - \$ per family	
f. Lifetime maximum benefit \$	

10. Physician Office Visits and Emergency Care - If 0, enter 0.

	Active Employees/Combined Plan % or %
Physician Office Visits	
a. Primary Care Physician CoPay \$ per visit	
b. Specialist CoPay \$ per visit	
c. % of charges paid by plan after copay or deductible	
Emergency Care	
d. Emergency Room CoPay \$	
e. % of charges paid by plan after copay or deductible	

11. Inpatient Hospital and Surgery - If 0, enter 0.

	Active Employees/ Combined Plan \$ or %
Inpatient Hospital	
a. Inpatient Hospital CoPay \$	
b. % of charges paid by plan after copay or deductible	
Inpatient Surgery	
c. Inpatient Surgery CoPay \$	
d. % of charges paid by plan after copay or deductible	
Outpatient Surgery	
e. Out patient Surgery CoPay \$	
f. % of charges paid by plan after copay or deductible	

12. Mental Health and Substance Abuse - If 0 or Unlimited, enter 0.

	Active Employees/Combined Plan \$ or %
Outpatient Mental Health/ Substance Abuse Care	
a. Outpatient Mental Health/ Substance Abuse CoPay \$	
b. % of charges paid by plan after copay or deductible	
c. Maximum # of mental health visits per year	
d. Maximum # of substance abuse visits per year	
Inpatient MH/SA Care	
e. Inpatient Mental Health/ Substance Abuse CoPay \$	
f. % of charges paid by plan after copay or deductible	
g. Maximum # of confinement days per year for MH/SA combined	
h. Lifetime limit on number of confinements	

13. Medical Therapy, Chiropractic, and Skilled Nursing - If 0 or Unlimited, enter 0.

	Active Employees/Combined Plan \$ or %
Physical, Occupational, and Speech Therapy	
a. P/O/S Therapy CoPay \$	
b. % of charges paid by plan after copay or deductible	
c. Maximum # of visits per year	
Chiropractic	
d. Chiropractic CoPay \$	
e. % of charges paid by plan after copay or deductible	
f. Maximum # of visits per year	
Skilled Nursing Facility	
g. SNF CoPay \$	
h. % of charges paid by plan after copay or deductible	
i. Maximum # of days per year	

14. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!

15. No question – reserved for future use.

20. Dental Plan Co-Pay and Coinsurance - Please enter the dollar or percentage amount as appropriate. If there is no copay or no coverage by the plan after the copay or deductible, enter 0 in the \$ column.

Dental Coverage: Active Employees/Combined Plan				
	In-Network		Out-of-Network	
	\$	%	\$	%
Diagnostic/Preventive Services				
a. CoPay				
b. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Basic Restorative Services				
c. CoPay				
d. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Major Restorative Services				
e. CoPay				
f. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Orthodontia Services				
g. CoPay				
h. Maximum \$ and/or % of charges paid by plan after copay or deductible				

VISION INSURANCE (SKIP Q. 21-23 IF NOT COVERED BY THIS MEDICAL PLAN)

21. What is the coverage period for the **first pair** of glasses or contacts?
- Benefits paid once every 12 months
 - Benefits paid once every 24 months
 - Benefits paid once every 36 months
 - Other coverage period

22. Please enter the dollar or percentage amount paid by this vision plan for an eye exam and the first pair of glasses or contacts. Also indicate the benefits, if any, paid by the plan for corrective laser eye surgery. If "Covered in full" enter 100%. Leave blank if not applicable.

	Vision Coverage: Active Employees/Combined Plan			
	In-Network		Out-of-Network	
	\$	%	\$	%
a. Eye exams				
b. Lenses (first pair)				
c. Frames (first pair)				
d. Contact lenses (first pair)				
e. Laser eye surgery				

23. Does this vision plan provide benefits for extra pairs of glasses or contacts?
- Yes
 - No

24. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!

7. Does this health care plan require **pre-certification** for the following?

	Yes	No	Not a Benefit
a. Inpatient hospital admission			
b. Outpatient mental health/ substance abuse care			
c. Inpatient mental health/ substance abuse care			
d. Home health care			
e. Home infusion therapy			
f. Hospice care			
g. Organ & tissue transplants			
h. Physical therapy			
i. Speech, occupational, vision, & hearing therapy			
j. Outpatient private nursing			
k. Skilled nursing facility admission			
l. Chiropractic services			
m. Does this plan require notification of emergency services within a specified time?			

8. What are the monthly contribution rates for this health care plan in effect as of January 1 of 2004-05 Academic Year? Use only the coverage categories that are appropriate. **If applicable, report HRA/HSA contribution separately;** leave blank otherwise. If your institution uses a tiered system based on salary, use the most representative rate, typically the one associated with the highest enrollment.

Active Employees/ Combined Plan	Employee's monthly contribution to Plan	Institution's monthly contribution to Plan	Institution's monthly contribution to HRA/HSA
a. Employee only			
b. Employee + 1			
c. Employee + Spouse			
d. Employee + Child(ren)			
e. Family			

9. Medical Deductibles, Coinsurance, and Maximums -If 0 or Unlimited, enter 0.

	Active Employees/ Combined Plan \$	
	In-Network	Out-of Network
a. Annual deductible - \$ per individual		
b. Annual deductible - \$ per family		
c. % paid by plan after deductible met		
d. Annual out-of-pocket maximum – \$ per individual		
e. Annual out-of-pocket maximum - \$ per family		
f. Lifetime maximum benefit \$		

10. Physician Office Visits and Emergency Care -If 0, enter 0.

	Active Employees/ Combined Plan \$ or %	
	In-Network	Out-of Network
Physician Office Visits		
a. Primary Care Physician CoPay \$ per visit		
b. Specialist CoPay \$ per visit		
c. % of charges paid by plan after copay or deductible		
Emergency Care		
d. Emergency Room CoPay		
e. % of charges paid by plan after copay or deductible		

11. Inpatient Hospital and Surgery - If 0, enter 0.

	Active Employees/ Combined Plan \$ or %	
	In-Network	Out-of Network
Inpatient Hospital		
a. Inpatient Hospital CoPay \$		
b. % of charges paid by plan after copay or deductible		
Inpatient Surgery		
c. Inpatient Surgery CoPay		
d. % of charges paid by plan after copay or deductible		
Outpatient Surgery		
e. Out patient Surgery CoPay		
f. % of charges paid by plan after copay or deductible		

12. Mental Health and Substance Abuse - If 0 or Unlimited, enter 0.

	Active Employees/ Combined Plan \$ or %	
	In-Network	Out-of Network
Outpatient Mental Health/ Substance Abuse Care		
a. Outpatient Mental Health/ Substance Abuse CoPay \$		
b. % of charges paid by plan after copay or deductible		
c. Maximum # of mental health visits per year		
d. Maximum # of substance abuse visits per year		
Inpatient MH/SA Care		
e. Inpatient Mental Health/ Substance Abuse CoPay \$		
f. % of charges paid by plan after copay or deductible		
g. Maximum # of confinement days per year for MH/SA combined		
h. Lifetime limit on number of confinements		

13. Medical Therapy, Chiropractic, and Skilled Nursing -If 0 or Unlimited, enter 0.

	Active Employees/ Combined Plan \$ or %	
	In-Network	Out-of Network
Physical, Occupational, and Speech Therapy		
a. P/O/S Therapy CoPay \$		
b. % of charges paid by plan after copay or deductible		
c. Maximum # of visits per year		
Chiropractic		
d. Chiropractic CoPay \$		
e. % of charges paid by plan after copay or deductible		
f. Maximum # of visits per year		
Skilled Nursing Facility		
g. SNF CoPay \$		
h. % of charges paid by plan after copay or deductible		
i. Maximum # of days per year		

14. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!

15. No question – reserved for future use.

PRESCRIPTION DRUG INSURANCE (SKIP Q. 16-18 IF NOT COVERED BY THIS MEDICAL PLAN)

16. Drug Plan Deductibles, Coinsurance, and Maximums - If 0 or *Unlimited*, enter 0.

**Drug Coverage: Active
Employees/Combined Plan
\$ or %**

- a. Annual deductible - \$ per individual
- b. Annual deductible - \$ per family
- c. % paid by plan after deductible met
- d. Annual out-of-pocket maximum – \$ per individual
- e. Annual out-of-pocket maximum - \$ per family
- f. Lifetime maximum benefit \$

17. Drug Plan Co-Payments - Please enter the dollar **or** percentage amount as appropriate, and also enter the supply limit in number of days. If 0 or *Unlimited*, enter 0 in the \$ column.

**Drug Coverage: Active
Employees/
Combined Plan**

- | Retail | \$ | % |
|---|-----------|----------|
| a. CoPay for Generic | | |
| b. CoPay for preferred brand (on formulary) | | |
| c. CoPay for non-preferred brand (not on formulary) | | |
| d. Deductible for retail | | |
| e. Supply limit – in # of days | | |
| Mail Order | | |
| f. CoPay for Generic | | |
| g. CoPay for preferred brand (on formulary) | | |
| h. CoPay for non-preferred brand (not on formulary) | | |
| i. Deductible for mail order | | |
| j. Supply limit – in # of days | | |

\$	%

18. Other Drug Policies

- a. Does the drug plan use a closed formulary
- b. Is mail order required?
- c. Are Rx benefits allowed for dental or dental trauma?

Yes	No

DENTAL INSURANCE (SKIP Q. 19-20 IF NOT COVERED BY THIS MEDICAL PLAN)

19. Dental Plan Deductibles and Maximums - If 0 or *Unlimited*, enter 0.

**Dental Coverage: Active
Employees/Combined Plan \$**

- a. Annual deductible \$ per individual
- b. Non-orthodontia annual maximum benefit \$ per individual
- c. Orthodontia annual maximum benefit \$ per individual
- d. Annual out-of-pocket maximum – \$ per individual
- e. Annual out-of-pocket maximum - \$ per family
- f. Lifetime maximum benefit \$

20. Dental Plan Co-Pay and Coinsurance - Please enter the dollar or percentage amount as appropriate. If there is no copay or no coverage by the plan after the copay or deductible, enter 0 in the \$ column.

Dental Coverage: Active Employees/Combined Plan				
	In-Network		Out-of-Network	
	\$	%	\$	%
Diagnostic/Preventive Services				
a. CoPay				
b. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Basic Restorative Services				
c. CoPay				
d. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Major Restorative Services				
e. CoPay				
f. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Orthodontia Services				
g. CoPay				
h. Maximum \$ and/or % of charges paid by plan after copay or deductible				

VISION INSURANCE (SKIP Q. 21-23 IF NOT COVERED BY THIS MEDICAL PLAN)

21. What is the coverage period for the first pair of glasses or contacts?

- Benefits paid once every 12 months
- Benefits paid once every 24 months
- Benefits paid once every 36 months
- Other coverage period

22. Please enter the dollar or percentage amount paid by this vision plan for an eye exam and the first pair of glasses or contacts. Also indicate the benefits, if any, paid by the plan for corrective laser eye surgery. If "Covered in full" enter 100%. Leave blank if not applicable.

	Vision Coverage: Active Employees/Combined Plan			
	In-Network		Out-of-Network	
	\$	%	\$	%
a. Eye exams				
b. Lenses (first pair)				
c. Frames (first pair)				
d. Contact lenses (first pair)				
e. Laser eye surgery				

23. Does this vision plan provide benefits for extra pairs of glasses or contacts?

- Yes
- No

24. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!

I. Stand-Alone Prescription Drug Plan

Do not answer this section if your drug plan is part of a health care plan.

Please report on the **Stand-Alone Drug Plan with the highest enrollment**. Report plan information as of January 1st of the 2004-05 academic year.

Note: Error messages suggesting a minimum or maximum value are provided as an aid only. You can over-ride the message by pressing the "Enter" key.

1. Is this stand-alone drug plan a **combined** plan that includes both active employees **and** retirees?
- Yes
- No

2. How many **Lives** (including dependents) are currently enrolled in this stand-alone drug plan?

Stand-Alone Drug Plan: Active Employees or Combined Plan

--

3. What is the budgeted or projected total cost of this stand-alone drug plan during the current plan year? Enter whole dollars. You may need to ask your controller.

Stand-Alone Drug Plan: Active Employees or Combined Plan

Institution's Total Cost	Employee Total Cost

4. Did the **cost of coverage** for this stand-alone drug plan change this year over last?
- Enter 0 if it stayed the same.
 - Enter a % **increase** in cost as a positive number to one decimal place (ex. 4.3).
 - Enter a % **decrease** in cost as a negative number to one decimal place (ex. -5.2).

	% increase or decrease
a. Institutional costs	
b. Employee costs	

5. What are the **monthly contribution rates** for this stand-alone drug plan in effect as of January 1 of the 2004-05 academic year? Use only the coverage categories that are appropriate. If your institution uses a tiered system based on salary, use the most representative rate, typically the one associated with the highest enrollment.

Stand-Alone Drug Plan: Active Employees/Combined Plan	Institution's monthly \$ contribution	Employee's monthly \$ contribution
a. Employee only		
b. Employee + 1		
c. Employee + Spouse		
d. Employee + Child(ren)		
e. Family		

6. Drug Plan Deductibles, Coinsurance, and Maximums - If 0 or Unlimited, enter 0.

**Drug Plan: Active
 Employees/Combined Plan
 \$ or %**

a. Annual deductible - \$ per individual	
b. Annual deductible - \$ per family	
c. % paid by plan after deductible met	
d. Annual out-of-pocket maximum – \$ per individual	
e. Annual out-of-pocket maximum - \$ per family	
f. Lifetime maximum benefit \$	

7. Drug Plan Co-Payments - Please enter the dollar or percentage amount as appropriate, and also enter the supply limit in number of days. If 0 or Unlimited, enter 0 in the \$ column.

		Drug Plan: Active Employees/Combined Plan	
Retail		\$	%
a.	CoPay for Generic		
b.	CoPay for preferred brand (on formulary)		
c.	CoPay for non-preferred brand (not on formulary)		
d.	Deductible for retail		
e.	Supply limit – in # of days		
Mail Order			
f.	CoPay for Generic		
g.	CoPay for preferred brand (on formulary)		
h.	CoPay for non-preferred brand (not on formulary)		
i.	Deductible for mail order		
j.	Supply limit – in # of days		

8. Other Drug Policies

	Yes	No
a. Does the drug plan use a closed formulary		
b. Is mail order required?		
c. Are Rx benefits allowed for dental or dental trauma?		

9. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!

J. Stand-Alone Dental Plan

Please report on the **Stand-Alone Dental Plan with the highest enrollment**. Report plan information as of January 1st of the 2004-05 academic year. **Do not answer this section if this drug plan is part of a health care plan.**

Note: Error messages suggesting a minimum or maximum value are provided as an aid only. You can over-ride the message by pressing the "Enter" key.

1. Is this stand-alone dental plan a **combined plan** that includes both active employees **and** retirees?
 Yes
 No

2. How many **Lives** (including dependents) are currently enrolled in this stand-alone dental plan?

Stand-Alone Dental Plan: Active Employees or Combined Plan

--

3. What is the budgeted or projected total cost of this stand-alone dental plan during the current plan year? Enter whole dollars. You may need to ask your controller.

Stand-Alone Dental Plan: Active Employees or Combined Plan

Institution's Total Cost	Employee Total Cost

4. Did the **cost of coverage** for this stand-alone dental plan change this year over last?
 Enter 0 if it stayed the same.
 Enter a % **increase** in cost as a positive number to one decimal place (ex. 4.3).
 Enter a % **decrease** in cost as a negative number to one decimal place (ex. -5.2).

	% increase or decrease
a. Institutional costs	
b. Employee costs	
b. Employee costs	

5. What are the **monthly contribution** rates for this stand-alone dental plan in effect as of January 1 of 2004-05 Academic Year? Use only the coverage categories that are appropriate. If your institution uses a tiered system based on salary, use the most representative rate, typically the one associated with the highest enrollment.

Stand-Alone Dental Plan: Active Employees/Combined Plan	Institution's monthly \$ contribution	Employee's monthly \$ contribution
a. Employee only		
b. Employee + 1		
c. Employee + Spouse		
d. Employee + Child(ren)		
e. Family		

6. Dental Plan Deductibles and Maximums - If 0 or *Unlimited*, enter 0.

- a. Annual deductible \$ per individual
- b. Non-orthodontia annual maximum benefit \$ per individual
- c. Orthodontia annual maximum benefit \$ per individual
- d. Annual out-of-pocket maximum – \$ per individual
- e. Annual out-of-pocket maximum - \$ per family
- f. Lifetime maximum benefit \$

Dental Plan: Active Employees/Combined Plan \$	

7. Dental Plan Co-Pay and Coinsurance - Please enter the dollar or percentage amount as appropriate. If there is no copay or no coverage by the plan after the copay or deductible, enter 0 in the \$ column.

	Dental Coverage: Active Employees/Combined Plan			
	In-Network		Out-of-Network	
	\$	%	\$	%
Diagnostic/Preventive Services				
a. CoPay				
b. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Basic Restorative Services				
c. CoPay				
d. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Major Restorative Services				
e. CoPay				
f. Maximum \$ and/or % of charges paid by plan after copay or deductible				
Orthodontia Services				
g. CoPay				
h. Maximum \$ and/or % of charges paid by plan after copay or deductible				

8. Does this dental plan provide the following plan types?

	Yes	No
a. HMO		
b. Traditional		
c. PPO		

9. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!

K. Stand-Alone Vision Plan

Please report on the **Stand-Alone Vision Plan with the highest enrollment**. Report plan information as of January 1st of the 2004-05 academic year. **Do not answer this section if this drug plan is part of a health care plan.**

Note: Error messages suggesting a minimum or maximum value are provided as an aid only. You can over-ride the message by pressing the "Enter" key.

1. Is this stand-alone vision plan a **combined** plan that includes both active employees **and** retirees?

- Yes
 No

2. How many **Lives** (including dependents) are currently enrolled in this stand-alone vision plan?

Stand-Alone Vision Plan: Active Employees or Combined Plan

--

3. What is the **budgeted or projected total cost** of this stand-alone vision plan during the current plan year? Enter whole dollars. You may need to ask your controller.

Stand-Alone Vision Plan: Active Employees or Combined Plan

Institution's Total Cost	Employee Total Cost

4. Did the **cost of coverage** for this stand-alone vision plan change this year over last?

- Enter 0 if it stayed the same.
- Enter a % **increase** in cost as a positive number to one decimal place (ex. 4.3).
- Enter a % **decrease** in cost as a negative number to one decimal place (ex. -5.2).

	% increase or decrease
a. Institutional costs	
b. Employee costs	

5. What are the **monthly contribution** rates for this stand-alone vision plan in effect as of January 1 of 2004-05 Academic Year? Use only the coverage categories that are appropriate. If your institution uses a tiered system based on salary, use the most representative rate, typically the one associated with the highest enrollment.

Stand-Alone Vision Plan: Active Employees/Combined Plan	Institution's monthly \$ contribution	Employee's monthly \$ contribution
a. Employee only		
b. Employee + 1		
c. Employee + Spouse		
d. Employee + Child(ren)		
e. Family		

6. What is the coverage period for the **first pair** of glasses or contacts?

- Benefits paid once every 12 months
 Benefits paid once every 24 months
 Benefits paid once every 36 months
 Other coverage period

7. Please enter the dollar or percentage amount paid by this stand-alone vision plan for an eye exam and the first pair of glasses or contacts. Also indicate the benefits, if any, paid by the plan for corrective laser eye surgery. If "Covered in full" enter 100%. Leave blank if not applicable.

- a. Eye exams
- b. Lenses (first pair)
- c. Frames (first pair)
- d. Contact lenses (first pair)
- e. Laser eye surgery

Stand-Alone Vision Plan: Active Employees/Combined Plan			
In-Network		Out-of-Network	
\$	%	\$	%

8. Does this stand-alone vision plan provide benefits for extra pairs of glasses or contacts?
 Yes
 No

9. Does this stand-alone vision plan provide the following plan types?

	Yes	No
a. HMO		
b. Traditional		
c. PPO		

10. Please use the space below to clarify your responses or otherwise comment on this section. Be sure to indicate the question number on any specific clarifications. You are allowed a maximum of 500 characters; so do keep your entry brief!