UNIVERSITY OF THE CUMBERLANDS MEDICAL BENEFITS SCHEDULE

November 1, 2019 – October 31, 2020

	NETWORK	NON-NETWORK
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Deductible (Single/Family)	$500/$1,000	$1,000/$2,000
Maximum Out-Of-Pocket (Single/Family) Maximum Excludes: • Cost Containment Penalties • Non-Network Transplant Charges	Medical:2,000/$4,000 Pharmacy:$2,500/$5,000	$4,000/$8,000
COVERED BENEFITS	**MEMBER COST SHARE RESPONSIBILITY**	
Physician Office Services		
Office Visit Copayment (PCP/SCP)	$20/$35	40%
Allergy Injection Copayment	$5	40%
Allergy Testing and Serum	20%	40%
Imaging Services (MRI, MRA, PETS,C-SCAN)	20%	40%
Diagnostic Testing in Office Visit (Lab and X-Ray)[1]	$20/$35	40%
Optometrist (1 eye exam annually and then as Medically Necessary for illness or injury)	$20	40%
Ophthalmologist	$35	40%
Preventive Care Services Office Visit Copayment Services Include But Not Limited To: • Routine Exams • Pelvic Exams • Mammogram[2] • PAP Testing • PSA Testing • Immunizations • Annual Diabetic Eye Exam • Vision & Hearing Screening • Physician Home and Office Visits • Breast Pumps – 1 per pregnancy[3] • Other Outpatient Services at Hospital or Alternative Care Facility	$0	40%
Emergency Room & Urgent Treatment Center Emergency Room Services Copayment Copayment Waived If Admitted Non-Emergency Care Not Covered	$200	$200
Urgent Treatment Center Services Copayment[4]	$35	40%
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity Related Ultrasounds, Pharmaceutical Products	20%	40%
• Allergy Injections[5]	$5	40%
• Allergy Testing	20%	40%

Inpatient & Outpatient Professional Services Services Include But Not Limited To: • Medical Care Visit (1 Per Day) • Intensive Medical Care • Concurrent Care • Consultations • Surgery • Anesthesia Administration • Newborn Exams	20%	40%
Inpatient Facility Services Unlimited Days Except For: • Sixty Days Network/Non-Network Combined For Physical Medicine & Rehabilitation (Limit Includes Day Rehabilitation Therapy Services On An Outpatient Basis) • Ninety Days Network/Non-Network Combined For Skilled Nursing Facility	20%	40%
Outpatient Surgery/Alternate Care Facility Surgery & Administration Of General Anesthesia	20%	40%
Other Outpatient Services Services Include But Not Limited To: • Non-Surgical Outpatient Services For Example: MRI, C-Scan, Chemotherapy, Ultrasounds, Other Diagnostic Services • 100 Visits Network/Non-Network Combined For Home Care Services (Excludes IV Therapy) • Durable Medical Equipment (excluding Prosthetic Devices, Limbs and Medical Supplies) • Orthotics • Prosthetic Devices & Limbs • Physical Medicine Therapy Day Rehabilitation Programs	20%	40%
Private Duty Nursing 82 visit maximum per calendar year and 164 visits per lifetime per member. Does not count toward the Home Health Care visit maximum.	20%	40%
Ambulance Services Ground & Air Ambulance	20%	20%
Hospice Care	Plan Covers 100% Of Charges To Medicare Allowable Amount	
Wig After Chemotherapy	20%	40%
Bereavement Counseling	Based On Place Of Service	40%
Autism Spectrum Disorders	20%	40%
Outpatient Therapy Services ***(Combined Network/Non-Network Limits Apply As Indicated)*** • Physician Home & Office Visit Copayment • Other Outpatient Services	 $20/$35 20%	 40% 40%

Limits Apply To: • Physical Therapy: 20 Visits* • Occupational Therapy: 20 Visits* • Manipulation Therapy: 12 Visits • Speech Therapy: 20 Visits* • Cardiac Rehabilitation: 36 Visits • Pulmonary Rehabilitation: 20 Visits * With prior authorization of the Claims Administrator, additional visits may be allowed for Physical Therapy, Occupational Therapy or Speech Therapy, however in no event may the combined total for these therapies exceed 60 visits.	 $20 $20 $20 $20 Based on Place of Service Based on Place of Service	
Durable Medical Equipment	20%	40%
Hearing Aids & Related Services Members Under Age 18	One Hearing Aid Per Hearing Impaired Ear Every Thirty-Six (36) Months NOTE: If durable medical equipment or appliances are obtained through your Primary Care Physician or another Network Physician's office, Urgent Care Center Services, Outpatient Services, Home Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where covered Services are received.	
Behavioral Health & Substance Abuse • Inpatient Facility Services • Inpatient Professional Services • Physician Office Visit Copayment (PCP/SCP) • Other Outpatient Services, Outpatient Facility at Hospital/Alternative Care Facility, Outpatient Professional	 20% 20% $20/$35 20%	 40%
Temporomandibular Joint Disorder Craniomandibular Jaw Disorder	Based On Place Of Service	Based On Place Of Service
Pregnancy (Dependent Daughters are Not Covered)	Based On Place Of Service	Based On Place Of Service
Dental Services Only When Related To Accidental Injury Or For Certain Members Requiring General Anesthesia	Based On Place Of Service	Based On Place Of Service
Diabetic Equipment, Education & Supplies Information	Copayments/Coinsurance Based On Place Of Service For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment and Appliances" provision in this Schedule. For information on Prescription Drug coverage, please refer to the "Prescription Drugs" provision in this Schedule. Screenings for gestational diabetes are covered under "Preventive Care."	

Diagnostic Services Information	When rendered as Physician Home Visits and Office Services or Outpatient Services the Co-payment/Coinsurance is based on the setting where Covered Services are received excpet as listed below. Other Diagnostic Services and or test, including services received at an independent Network lab, may not require a Copayment/Coinsurance. Laboratory services provided by a facility participating in the Administrator's Laboratory Network (as shown in the Provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient hospital laboratory which is not part of the Administrator's Laboratory network, even if it is a Network Provider for other services they will be covered as an Outpatient Services benefit. Note: MRA, MRI, PET scan, nuclear cardiology imaging studies, and on maternity related ultrasound services are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.	
Human Organ & Tissue Transplants[6] Acquisition & Transplant Procedures • Transportation and Lodging: Maximum $10,000 per benefit. • Unrelated donor searches for bone marrow/stem cell transplants: Maximum $30,000 per benefit.	Plan Covers 100% Of Charges	50%

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

COVERED BENEFITS	MEMBER COST SHARE RESPONSIBILITY	
Retail Pharmacy (30 Day Supply)		
Tier I Copayment	$10	
Tier II Coinsurance	20% ($20 min/$50 max)	50%, minimum $60
Tier III Coinsurance	25% ($30 min/$100 max)	
Tier IV Coinsurance	25%, $150 per Rx max	
Direct Mail Service (90 Day Supply)		Not Covered
Tier I Copayment	$30	
Tier II Coinsurance	20% ($60 min/$150 max)	
Tier III Coinsurance	25% ($90 min/$300 max)	
Tier IV Coinsurance	25%, $150 per Rx max	
Maximum Out-Of-Pocket; All Prescription Drugs (Single/Family)	$2,500 /$5,000	
Member may be responsible for additional cost when not selecting the available generic drug. Medicare Rx - Wrap		
Specialty medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.		
Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail order.		

Schedule of Benefits Notes:

Non-Network Transplant Charges Are Excluded From Out-Of-Pocket Limits

Deductibles apply only to Covered Medical Services listed with a Coinsurance Percentage and do not apply where a fixed dollar copayment is required, unless otherwise noted.

Network and Non-Network Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums are separate and accumulate separately.

Dependent Coverage to the end of the Calendar Month which Child attains age 26.

No Deductible/Copayment/Coinsurance means No Cost Share up to the Maximum Allowable Amount.

PCP Is a Network Provider who is a Practitioner that specializes in Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics or Any Other Network Provider as allowed by The Plan.

SCP Is a Network Provider, other than a Primary Care Physician (PCP), who provides services within a designated Specialty Area of Practice.

Certain Diabetic and Asthmatic Supplies have no Deductible/Copayment/Coinsurance up to the Maximum Allowable Amount at Network pharmacies.

Physician Office Visit Copayment is also applicable if the Office Visit is billed with Allergy Injections. Benefit Period Is on a Calendar Year Basis beginning January 1st and ending December 31st.

“Based on Place of Service” means that the Member cost share responsibility is determined by the type of facility that the service is performed in and how the service is billed by the provider.

[1] All Diagnostic Lab and X-Ray billed as part of the Office Visit with the exception of MRI, MRA, PETS, and C-SCAN will not require additional cost share beyond the Office Visit Copayment.

[2] Diagnostic Mammograms and Preventive Mammograms are covered at 100%

[3] Must be provided by an in network DME (Durable Medical Equipment) Provider. Member will not be reimbursed for a breast pump purchased from a retail store.

[4] Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center are subject to the Other Outpatient Services Copayment / Coinsurance.

[5] The Allergy Injection Copayment/Coinsurance will be applied when the injection is billed by itself. The Urgent Care visit Copayment/Coinsurance will apply if an Urgent Care visit is billed with an Allergy Injection.

[6] Transplants are covered at 100%, except Kidney and cornea transplants are treated the same as any other illness and subject to medical benefits, during the Transplant Benefit Period. The Transplant Benefit Period starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. For specific Transplant questions, contact ARC Administrators and ask to speak with someone regarding Transplants. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Visits/Office Services depending on where the service is performed.