BEREA COLLEGE MEDICAL BENEFITS SCHEDULE
PREMIUM PLAN
JULY 1, 2017 – JUNE 30, 2018

	NETWORK	NON-NETWORK
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Deductible (Single/Family) • No Individual will satisfy more than their Individual amount.	$750/$1,500	$1,500/$3,000
Maximum Out-Of-Pocket (Single/Family) Maximum Excludes: • Cost Containment Penalties • Non-Network Transplant Charges	Medical: $2,250/$4,500 Pharmacy: $4,350/$8,700	$4,500/$9,000
COVERED BENEFITS	**YOUR COST SHARE RESPONSIBILITY**	
Physician Office Services		
• Office Visit	$20/$40 copayment	40% after Deductible
• Allergy Injection	$5 copayment	40% after Deductible
• Allergy Testing & Serum	20% after Deductible	40% after Deductible
• Imaging Services (MRI, MRA, PETS,C-SCAN)	20% after Deductible	40% after Deductible
• Annual Eye Exam (Optometrist or Ophthalmologist)	$20/$40 copayment	40% after Deductible
Live Health Online	$10 copayment	40% after Deductible
Preventive Care Services Office Visit Copayment Services Include But Not Limited To: • Routine Exams • Colonoscopy • Mammogram[1] • PAP/PSA Testing • Immunizations • Annual Diabetic Eye Exam • Diabetic Education • Vision & Hearing Screening • Breast Pumps – 1 Pump Per Pregnancy[2]	No Cost Share	40% after Deductible

COVERED BENEFITS	YOUR COST SHARE RESPONSIBILITY	
Emergency Room & Urgent Treatment Center Emergency Room Services Copayment Copayment Waived If Admitted Non-Emergency Care Not Covered	$150 copayment	$150 copayment
Urgent Treatment Center Services[3] MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity related Ultrasounds and Pharmaceuticals	$50 copayment See Notes Section	$50 copayment See Notes Section
• Allergy injections (if billed alone)[4]	$5 copayment	40% after Deductible
• Allergy testing & serum	20% after Deductible	40% after Deductible
Inpatient 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	0% after Deductible	40% after Deductible
Inpatient Facility Services Unlimited Stays Except For: • 60 Days Network/Non-Network Combined For Physical Medicine & Rehabilitation (Limit Includes Day Rehabilitation Therapy Services On An Outpatient Basis) • 90 Days Network/Non-Network Combined For Skilled Nursing Facility	0% after Deductible	40% after Deductible
Outpatient Surgery/Alternate Care Facility Surgery & Administration of General Anesthesia	0% after Deductible	40% after Deductible
Other Outpatient Services Services Include But Not Limited To: • Non-Surgical Outpatient Services For Example: MRI, C-Scan, Chemotherapy, Ultrasounds, Other Diagnostic Services • 100 Network/Non-Network Visits Combined For Home Care Services (Excludes IV Therapy) • Durable Medical Equipment (Includes Hearing Aids and Related Services for Members under 18 Years of Age. 1 Hearing Aid per Ear every 36 Months.)	20% after Deductible	40% after Deductible
Autism	Based on Place of Service	40% after Deductible
Accidental Dental Injury	Based on Place of Service	40% after Deductible
Maternity (Dependent Daughters are Covered)	$800 copayment	40% after Deductible

COVERED BENEFITS	YOUR COST SHARE RESPONSIBILITY	
Ambulance Services	20% after Deductible	20% after Deductible
Hospice Care	No Cost Share	No Cost Share
Wig After Chemotherapy (1 wig per year)	20% after Deductible	40% after Deductible
Bereavement Counseling	Based on Place of Service	40% after Deductible
Private Duty Nursing (90 Visit Limit Per Year)	20% after Deductible	40% after Deductible
Outpatient Therapy Services ***(Combined Network/Non-Network Limits Apply As Indicated)***		
Physician Office Visits		
Limits Apply To:		
• Physical Therapy: 20 Visits	$20 copayment	40% after Deductible
• Occupational Therapy: 20 Visits	$20 copayment	40% after Deductible
• Manipulation Therapy: 15 Visits	$20 copayment	40% after Deductible
• Speech Therapy: 20 Visits	$20 copayment	40% after Deductible
• Pulmonary Rehab	Based on Place of Service	40% after Deductible
• Cardiac Rehab	Based on Place of Service	40% after Deductible
Other Outpatient Services	20% after Deductible	40% after Deductible
Behavioral Health & Substance Abuse		
• Inpatient Facility Services	0% after Deductible	40% after Deductible
• Inpatient Professional Services	0% after Deductible	40% after Deductible
• Physician Office Visit Copayment (PCP/SCP)	$20/$20 copayment	40% after Deductible
• Other Outpatient Services	20% after Deductible	40% after Deductible
Human Organ & Tissue Transplants[5]	No Cost Share	50% after Deductible

BEREA COLLEGE PHARMACY BENEFIT SCHEDULE – PREMIUM PLAN	
Retail Pharmacy (30 Day Supply)	
Tier 1 Copayment	$8
Tier 2 Copayment	$35
Tier 3 Copayment	$50
Tier 4 Coinsurance	25%, max $100
Direct Mail Service (90 Day Supply)	
Tier 1 Copayment	$16
Tier 2 Copayment	$75
Tier 3 Copayment	$125
Tier 4 Coinsurance	Not Covered

Benefit Schedule Notes:

All Medical Copayments are included in the Out-Of-Pocket Limits. Cost Containment Penalties and Non-Network Transplant Charges are excluded from Out-Of-Pocket Limits.

Deductibles apply to Covered Medical Services when specifically stated, and when listed with a Coinsurance Percentage. Deductibles do not apply where a fixed dollar copayment is required.

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 Year 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.

All Specialty Medications must be obtained via the Specialty Pharmacy network in order to receive network level benefits.

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

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.

[1]Diagnostic Mammograms are covered the same as preventive Mammograms.

[2]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/online store.

[3]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.

[4]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.

[5]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.