2019 SUMMARY OF BENEFITS

BENEFITS AT A GLANCE

BENEFITS	TIER- I UHC/MEDSTAR Quest Diagnostic	TIER- II IN-NETWORK PayerFusion Network	TIER- III OUT-OF-NETWORK Usual & Customary
LIFETIME MAXIMUM PER PERSON	UNLIMITED		
ANNUAL MAXIMUM PER YEAR	UNLIMITED		
ANNUAL OUT OF POCKET MAXIMUM PER PLAN YEAR	$6,250 INDIVIDUAL / $12,500 FAMILY		
ANNUAL DEDUCTIBLE	$0	$450	$600
UNIVERSITY HEALTH CENTER & COUNSELING CENTER	UNIVERSITY HEALTH CENTER & COUNSELING CENTER		
OFFICE VISITS	100%		
ON-CAMPUS MENTAL HEALTH VISIT	100%		
PRESCRIPTIONS	100%		
INPATIENT			
HOSPITAL ROOM AND BOARD (HRB OR BASIC)	90%	80%	60% of usual and customary
INTENSIVE CARE	90%	80%	60% of usual and customary
PHYSICIAN HOSPITAL VISIT (PHV)	90%	80%	60% of usual and customary
SURGICAL EXPENSE	90%	80%	60% of usual and customary
ANESTHESIA	90%	80%	60% of usual and customary
ASSISTANT SURGEON	90%	80%	60% of usual and customary
SKILLED NURSE LIMITED: 90 DAYS/BENEFIT PERIOD	90%	80%	60% of usual and customary
TRANSPLANT SERVICES	90%	80%	60% of usual and customary
PHYSIOTHERAPY	90%	80%	60% of usual and customary
ANESTHESIA	90%	80%	60% of usual and customary
PSYCHOTHERAPY	90%	80%	60% of usual and customary
OUTPATIENT			
SURGICAL EXPENSE & DAY SURGERY MISCELLANEOUS	$150 copay then 90%	$150 copay then 80%	$150 copay then 60% of usual & customary
OUTPATIENT PHYSICIAN'S VISIT (OPV)	$15 copay then 100% with referral	80%	60% of usual and customary
INJECTIONS (OPV)	90%	80%	60% of usual and customary
URGENT CARE EXPENSES	$15 copay then 100% with referral	80%	60% of usual and customary
MEDICAL EMERGENCY VISIT	$300 copay, then 90% (Co-pay only, plan deductible waived unless admitted into the hospital.)	$300 copay, then 80% (Co-pay only, plan deductible waived unless admitted into the hospital.)	$300 copay, then 60% of usual & customary (Co-pay only, plan deductible waived unless admitted into the hospital.)

2019 SUMMARY OF BENEFITS

BENEFITS AT A GLANCE - CONTINUED

BENEFITS - CONTINUED

OUTPATIENT

	TIER- I UHC/MEDSTAR Quest Diagnostic	TIER- II IN-NETWORK PayerFusion Network	TIER- III OUT-OF-NETWORK Usual & Customary
PHYSIOTHERAPY	90% for visits 1-25, then 60%	80% for visits 1-25, then 60%	60% of usual and customary
CHIROPRACTIC (VISITS 1-25 ARE COMBINED FOR TIER 1 & 2)	90% for visits 1-25, then 60%	80% for visits 1-25, then 60%	60% of usual and customary
LABORATORY & X-RAY EXPENSE	$10 copay then 90%	$10 copay then 80%	$10 copay then 60% of usual & customary
TEST & PROCEDURES	90%	80%	60% of usual and customary
INJECTIONS	90%	80%	60% of usual and customary
PREVENTATIVE & WELLNESS BENEFITS (HCR)	100%	100%	60% of usual and customary
OBGYN (ANNUAL EXAM)	100%	100%	60% of usual and customary
PSYCHOTHERAPY	90%	80%	60% of usual and customary

ADDITIONAL BENEFITS

DURABLE MEDICAL EQUIPMENT (Precondition required over $500)	80%	80%	80% of usual and customary
INFERTILITY (COUNSELING, TESTING & TREATMENT)	80% UP TO $750, 60% THEREAFTER		
TRANSSEXUALISM/ GENDER IDENTITY	80% UP TO $750, 60% THEREAFTER		
INTRAMURAL SPORTS	PAID AS ACCIDENT		
TREATMENT FOR TMJ	80%	80%	80% of usual and customary
AMBULANCE	90%	90%	90% of usual and customary
DENTAL TREATMENT, INJURY TO SOUND TEETH ONLY	PAID AS ACCIDENT		
TERM LIFE INSURANCE	$10,000		
ACCIDENTAL DEATH & DISMEMBERMENT	$10,000		

PHARMACY BENEFITS

	EHIM NETWORK	TIER- II IN-NETWORK
PRESCRIPTION MAXIMUM	UNLIMITED	
PHARMACY SUPPLY LIMIT DEDUCTIBLE	31 Days or 101 Tablets Plan deductible does not apply to prescription medications, only copay and coinsurance	
TIER 1	$15 + 20%	$15 + 40%
TIER 2	$30 + 20%	$30 + 40%
TIER 3	$50 + 20%	$50 + 40%
CONTRACEPTIVES	100%	100%
90 DAYS MAINTENANCE SUPPLY	2.5x Copayments + 20%	2.5x Copayments + 40%