FLORIDA MEMORIAL UNIVERSITY

SCHEDULE OF BENEFITS

Verification of Eligibility: PayerFusion Holdings, LLC (866) 752-8881

Call this number to verify eligibility for Plan benefits **before** medical services are rendered.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of the Plan document.

Note: The following services must be precertified:

PayerFusion Holdings, LLC: Phone: +1(866) 752-8881
Fax: (305) 384-7059

Phone Hours: 9:00 am - 6:00 pm EST.

All Inpatient Admissions

Acute
Long-Term Acute Care
Rehab
Skilled Nursing Facility
Mental Health / Substance Abuse

Outpatient – Surgery

Back Surgeries
Osteochondral Allograft, knee
Hysterectomy (including prophylactic)
Autologous chondrocyte implantation, Caritcel
Cosmetic Procedures, included but not limited to

- Abdominoplasty
- Blepharoplasty
- Cervicoplasty (neck lift)
- Facial skin lesions (MOHS, Photo therapy, laser therapy)
- Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
- IDET (Thermal Intradiscal Procedures)
- Liposuction/lipectomy
- Mammoplasty, augmentation and reduction (includes removal of implant)
- Mastectomy, gynecomastia and prophylactic
- Morbid obesity procedures
- Orthognathic procedures (ex: Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Otoplasty
- Palatopharyngoplasty (UPPP for snoring)
- Panniculectomy
- Rhinoplasty
- Rhytidectomy
- Scar revisions
- Septoplasty
- Varicose vein surgery/sclerotherapy

Outpatient – Diagnostic Services

- MRI/MRA/MRV, PET, CT, Cardiac Computed Tomographic Angiography (CCTA), CT Angiography (CTA)
- Sleep Studies
- U.S. bone density (heel only)
- Scintimammography
- Genetic Testing
- Chemotherapy
- Radiation
- Dialysis
- Experimental/Investigational Procedures (this is dependent on what the Plan defines as E/I)
- Hyperbaric Oxygen
- Injectables, excluding vaccinations – all Injectables that cost $2,000 or more per drug per month
- Outpatient Physical Therapy
- Outpatient Subacute
    - Home Health Care
    - Home infusions, excludes antibiotics
    - Durable Medical Equipment – all DME that costs $500 or more

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services: Usual and Customary applies

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within a 50 mile radius of the patient's residence.

If a Covered Person is in or out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician, anesthesia or ancillary services by a Non-Network Provider at an In-Network facility.

Deductibles and certain Copayments are payable by Plan Participants.

Copayments and Deductibles are dollar amounts that the Covered Person must pay before the Plan pays. See the Schedule of Benefits for details.

A deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan Year and it must be paid before any money is paid by the Plan for any Covered Charges. Each August 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments accrue toward the 100% maximum out-of-pocket payment.

Information and Records Disclaimer

At times the Plan may need additional information from the participants in order to furnish the Plan with all information and proofs that the Plan may reasonably require regarding any matters pertaining to the Policy. If the Participants do not provide this information when requested, it may delay or deny payment of their Benefits.

By accepting Benefits under this Plan, they authorize and direct any person or institution that has provided services to them to furnish the Plan with all information or copies of records relating to the services provided. The Plan has the right to request this information at any reasonable time. This applies to all Covered Participants, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. The Plan agrees that such information and records will be considered confidential.

MEDICAL BENEFITS SCHEDULE
COMPREHNSIVE PLAN

	GROUP SPECIFIC NETWORK	PAYERFUSION NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT	UNLIMITED		
Note: The Network deductibles and out-of-pocket amounts ARE NOT applied to the Non-Network deductibles and out-of-pocket amounts. The Non-Network deductibles and out-of-pocket amounts ARE NOT applied to the Network deductibles and out-of-pocket amounts. Deductibles do not apply when a Copayment is required.			
DEDUCTIBLE, PER PLAN YEAR			
Per Covered Person	$0	$250	$500
OUT-OF-POCKET MAXIMUM, PER PLAN YEAR			
Individual/Family	$6,250/$12,500		$6,250/$12,500
STUDENT HEALTH CENTER			
Office visits	100%		
On-campus Mental Health visit	100%		
Prescriptions	$5/$15/$30		
Labs & X-rays, Tests & Procedures	100%	Paid based on where the specimen or x-ray was taken	
INPATIENT			
Inpatient Hospital Expenses (precertification required)	90%	80%	60% of usual and customary
Surgical Expenses, Anesthesia, Assistant Surgeon	90%	80%	60% of usual and customary
Intensive Care Unit (precertification required)	90%	80%	60% of usual and customary
Transplant Services (precertification required)	90%	80%	60% of usual and customary
Mental Health & Substance Abuse (precertification required)	90%	80%	60% of usual and customary
Rehabilitative and Habilitative Services (Physical, Speech, Occupational, and Cardiac Therapy, Chemotherapy, Radiation Therapy) (precertification required)	90%	80%	60% of usual and customary
Skilled Nursing (90 days plan year maximum)	90%	80%	60% of usual and customary
OUTPATIENT BENEFITS			
Surgical Expenses (precertification required)	90%	80%	60% of usual and customary
Primary Care Visit to treat an injury or illness	90%	80%	60% of usual and customary
Specialist Visit	90%	80%	60% of usual and customary

Other Practitioner Office Visit	90%	80%	60% of usual and customary
Emergency Medical Transportation	90%	90%	90% of usual and customary

Urgent Care Facility	90%	80%	60% of usual and customary
Habilitative and Rehabilitative (Physical, Speech, Occupational, and Cardiac Therapy) (precertification required)	90% for visits 1-25, then 60%	80% for visits 1-25, then 60%	60% of usual and customary
	Visits 1-25 are combined for Tiers 1 & 2		
Chiropractic	90% for visits 1-25, then 60%	80% for visits 1-25, then 60%	60% of usual and customary
	Visits 1-25 are combined for Tiers 1 & 2		
Emergency use of the Emergency Room (non Medical Emergency not covered)	$100 copay	Deductible then $100 copay, then 80%	Deductible then $100 copay, then 80% of usual and customary
Laboratory & X-ray Expense	90%	80%	60% of usual and customary
Tests & Procedures	90%	80%	60% of usual and customary
Injections	90%	80%	60% of usual and customary
Mental Health & Substance Abuse	90%	80%	60% of usual and customary
MRI/CAT/MRA/PET scans (precertification required)	90%	80%	60% of usual and customary
Renal Dialysis (precertification required)	90%	80%	60% of usual and customary
PEDIATRIC VISION CARE			
Exam, including fitting and follow-up care for regular contact lenses	N/A	100% (one per year)	Up to $30 (one pair of glasses total per year)
Single Vision Lenses	N/A	100% (one pair of glasses total per year)	Up to $25 (one pair of glasses total per year)
Bifocal Lenses	N/A	100% (one pair of glasses total per year)	Up to $35 (one pair of glasses total per year)
Trifocal Lenses	N/A	100% (one pair of glasses total per year)	Up to $45 (one pair of glasses total per year)
Lenticular Lenses	N/A	100% (one pair of glasses total per year)	Up to $45 (one pair of glasses total per year)
Evaluation and fitting for specialty lenses (including, but not limited to, toric, multifocal, and gas permeable lenses)	N/A	Up to $60 (one per year)	Up to $60 (one per year)

Elective Contact Lenses	N/A	Up to $150 (in lieu of glasses)	Up to $75 (in lieu of glasses)
Medically Necessary Contact Lenses	N/A	Up to $600	Up to $225
Frames	N/A	Up to $150 (one pair of glasses total per year)	Up to $30 (one pair of glasses total per year)
PEDIATRIC DENTAL CARE			
Class A - Basic	100%	100%	90% of usual and customary
Class B - Intermediate	70%	70%	60% of usual and customary
Class C - Major	50%	50%	40% of usual and customary
Class D - Orthodontic	50%	50%	50% of usual and customary
ADDITIONAL BENEFITS			
Prenatal and Postnatal Care	90% (100% for Preventive services)	80%	60% of usual and customary
Durable Medical Equipment (precertification required if over $500)	80%	80%	80% of usual and customary
Home Health Care (precertification required)	90%	80%	60% of usual and customary
Hospice (precertification required)	90%	80%	60% of usual and customary
Treatment for TMJ	80%	80%	80% of usual and customary
Infertility (Counseling, Testing & Treatment)	80% up to $750, then 60%		
Transexualism/ Gender Identity	80% up to $750, then 60%		
Club Sports maximum of $500	90%	80%	60% of usual and customary
Intramural Sports maximum of $500	90%	80%	60% of usual and customary

	GROUP SPECIFIC PROVIDERS	PAYERFUSION NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PREVENTIVE SERVICES & WELLNESS BENEFITS			
Adult Preventive Care/ Screening/ Immunization	100%	100%	60% of usual and customary

- Abdominal Aortic Aneurysm (Once per lifetime screening for men);
- Alcohol Misuse screening/counseling;
- Aspirin use for men and women of certain ages;
- Blood Pressure screening;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal Cancer screening for adults over 50;
- Depression screening;
- Type 2 Diabetes screening for adults with high blood pressure;
- Diet counseling for adults at higher risk for chronic disease;
- HIV screening for adults;
- Immunization vaccines: (Doses, ages, and recommended populations vary);
  - Hepatitis A;
  - Hepatitis B;
  - Herpes Zoster;
  - Human Papillomavirus;
  - Influenza;
  - Measles, Mumps, Rubella;
  - Meningococcal;
  - Pneumococcal;
  - Tetanus, Diphtheria, Pertussis;
  - Varicella;
  - Anthrax;
  - BCG (tuberculosis);
  - Japanese encephalitis;
  - Rabies;
  - Smallpox;
  - Typhoid;
  - Yellow fever
- Obesity screening and counseling;
- Sexually Transmitted Infection (STI) prevention counseling for higher risk;
- Tobacco Use counseling and interventions;
- High blood pressure screening;
- Syphilis screening for higher risk;
- Falls prevention in older adults;
- Hepatitis C virus infection screening: adults;
- Lung cancer screening;
- Hepatitis B screening;
- Skin cancer behavioral counseling.

Women's Preventive Care Services	100%	100%	60% of usual and customary

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women with higher risk
- Breast cancer Mammography screenings
- Breast cancer Chemoprevention counseling for women at higher risk
- Breast Feeding intervention to support and promote breast feeding
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Folic Acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 640 depending on risk factors
- Rh Incompatibility screening for pregnant women & follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling
- Syphilis screening for all pregnant women or women at higher risk • Screening for gestational diabetes
- Human papillomavirus testing
- Counseling for sexually transmitted diseases
- Counseling for screening for human immune-deficiency virus
- FDA-approved female prescription contraceptive drugs and devices (e.g. diaphragm)
- FDA-approved female prescription contraceptive surgical procedures (e.g. IUD's)
- FDA-approved emergency contraceptive drugs
- Breastfeeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence
- Preeclampsia prevention: aspirin;
- HIV counseling and screening;

Child and Adolescent Preventive Care/ Screening/ Immunization	100%	100%	60% of usual and customary

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk for lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of newborns
- Hearing screening for newborns
- Height, Weight and Body Mass Index measurements
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathis or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines: (Doses, ages, and recommended populations vary)
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
  - Anthrax;
  - BCG (tuberculosis);
  - Japanese encephalitis;
  - Rabies;
  - Smallpox;
  - Typhoid;
  - Yellow fever;
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Visual acuity screening between ages 3 and 5;
- Dental caries prevention: infants and children up to age five years;
- Depression screening: adolescents;
- Hepatitis B screening: adolescents;
- Tobacco use interventions;
- Skin cancer behavioral counseling.

PRESCRIPTION DRUG BENEFIT SCHEDULE

	STUDENT HEALTH CENTER	EHIM NETWORK PROVIDERS	NON-NETWORK PROVIDERS
RETAIL 30-DAY SUPPLY			
Tier 1 – Generic Drugs	$5 copayment	$5 copayment + 20%	$5 copayment + 40%
Tier 2 – Preferred Drugs	$15 copayment	$15 copayment + 20%	$15 copayment + 40%
Tier 3 – Non-Formulary Drugs	$30 copayment	$30 copayment + 20%	$30 copayment + 40%
Contraceptive	100%	100%	100%
MAIL ORDER 90-DAY SUPPLY			
Tier 1 – Generic Drugs	N/A	$12.50 copayment + 20%	$12.50 copayment + 40%
Tier 2 – Preferred Drugs	N/A	$37.50 copayment + 20%	$37.50 copayment + 40%
Tier 3 – Non-Formulary Drugs	N/A	$75 copayment + 20%	$75 copayment + 40%