EMPLOYEE GROUP HEALTH PLAN

PENSACOLA CHRISTIAN COLLEGE
and Affiliates

Administered by:
Alternative Insurance Resources, Inc.
P.O. Box 660787
Birmingham, AL 35266-0787
Group# 22010
https://yourtpa.com/
1-800-451-4318

Pre-certification prior to hospitalization, surgery (in or out-patient) or durable medical equipment over $1000 by:
MedWatch
1-888-589-6460

PCC Local Providers Network:
(850) 478-8496 Ext 2789
employeeservices.me/GroupHealthPlan

PPO Physician Provider:
PHCS Practitioner Only
1-866-807-6193
https://www.multiplan.com/webcenter/portal/ProviderSearch

Pharmacy coverage is administered by
Liviniti (Southern Scripts) 1-800-710-9341
https://www.liviniti.com

ARTICLE XI – SCHEDULE OF BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully in this Summary Plan Description (SPD) including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Reasonable and Appropriate; that services, supplies and care are not Experimental and/or Investigational (except as required under the Patient Protection and Affordable Care Act). The meanings of these capitalized terms are in the Defined Terms section of this SPD. **In addition, you must read the section of this SPD entitled "Cost Management Services" to fully understand the Plan's pre-authorization requirements for hospital admissions, outpatient surgeries and durable medical equipment over $1000.**

Verification of Eligibility 800-451-4318. Call this number to verify eligibility for Plan benefits **before** the charge is incurred or go to www.yourtpa.com.

BENEFIT	PPO PROVIDERS	NON-PPO PROVIDERS
SUMMARY OF COST SHARING		
Plan Year Deductible	$ 1,500 per covered person $ 3,000 per family	$ 6,000 per covered person $ 12,000 per family
Plan Year Out of Pocket Maximum	$7,900 for Single $15,800 for all other	Unlimited
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS		
Preadmission Certification required for all Inpatient admissions (except maternity); notification within 48 hours of emergencies.		
Inpatient Hospital	Covered at 100% after plan year deductible and $250 per admission copay	Covered at 80% after plan year deductible and $500 per admission copay
Nursery (Family Plans Only)	100% with deductible waived (if routine well baby care); 100% after plan year deductible (other than routine – medical diagnosis)	80% with deductible waived (if routine well baby care); 80% after plan year deductible (other than routine – medical diagnosis)
Inpatient Physician Visits and Consultations	Covered at 100% after plan year deductible	Covered at 80% after plan year deductible
OUTPATIENT HOSPITAL BENEFITS		
Outpatient Surgery (including Ambulatory Surgical Centers) – inclusive of all related hospital and physician charges	Covered at 100% after $250 copay; deductible waived	Covered at 80% after $300 copay with deductible waived
Imaging: MRI, CT scans, PET scans	Covered at 100% after $100 copay with deductible waived when performed at independent facility; 100% after $300 copay with deductible waived when done or billed through hospital	Covered at 80% after $300 copay with deductible waived when performed at independent facility; 80% after $600 copay with deductible waived when done or billed through hospital
Emergency Room	Covered at 100% after plan year deductible	Covered at 100% after plan year deductible
Outpatient Diagnostic Lab, Xray & Pathology, Therapy	Covered at 100% after $100 hospital copay; deductible waived	Covered at 80% after plan year deductible and $300 copay

Pre-Admission Testing	Covered at 100%, deductible waived	Covered at 80%, deductible waived
PHYSICIAN BENEFITS		
Office Visits – Primary/Urgent Care (not including lab/x-ray services performed during visit)	PCC Local Providers Network – 100% after $25 copay PPO Physician Provider - $100% after $40 copay	Covered at 80% after plan year deductible
Office Visit – Specialist (not including lab/x-ray services performed during visit)	PCC Local Providers Network – 100% after $25 copay PPO Physician Provider - $100% after $50 copay	Covered at 80% after plan year deductible
Second/Third Surgical Opinions	Covered at 100% with deductible waived	Covered at 80% after plan year deductible
Inpatient Physician	Covered at 100% after plan year deductible	Covered at 80% after plan year deductible
Inpatient Physician Well Newborn Baby Care	Covered at 100%	Covered at 80% after plan year deductible
Telephone and Online Video Telehealth Services	PCC Local Providers Network – 100% after $25 copay PPO Physician Provider – 100% after $40 copay for primary and urgent care and $50 copay for specialist Teladoc™ $0 copay	Covered at 80% after plan year deductible
All Other Physician Outpatient Hospital Services	Covered at 100% after plan year deductible	Covered at 80% after plan year deductible
Emergency Room Physician	Covered at 100% after plan year deductible	Covered at 100% after plan year deductible
All Other Emergency Room Services	Covered at 100% after plan year deductible	Covered at 100% after plan year deductible
Lab/X-ray/Diagnostic Testing/Therapy and all Other Office Procedures (services received at either physician's office or independent lab facility)	Covered at 100% after $25 copay with deductible waived	Covered at 80% after $80 copay with deductible waived
PREVENTATIVE CARE		
Routine Immunizations and Preventative Services – limited to immunizations and preventative services required to be covered under the Affordable Care Act – see https://www.yourtpa.com/	Covered at 100%; no copay or deductible	Not covered
Note: In case of illness or family history of cancer, services generally are not considered preventative and may be covered by other plan provisions.		
BENEFITS FOR OTHER COVERED SERVICES		
Ambulance Services	Covered at 100% after plan year deductible	Covered at 80% after plan year deductible
Durable Medical Equipment (DME) (precertification required for purchases over $1000)	Covered at 100% up to $1,000 with deductible waived; after $1,000 covered at 80% with deductible waived	Covered at 80% after plan year deductible

Prosthetics, Orthotics, and Medical Supplies	Covered at 100% after plan year deductible	Covered at 80% after plan year deductible
Transplant Procedures	Must utilize a Center of Excellence for Transplant procedures. Transplant coverage subject to all other plan exclusions and limitations	Not Covered
Spinal Manipulation/Chiropractic Services	Maximum allowable charge $40 per visit with a $25 copay	Not covered
Other Covered Services	Covered at 100% after Plan Year Deductible	Covered at 80% after plan year deductible
Substance Abuse Treatment	Not Covered	Not Covered

HOME HEALTH, SKILLED NURSING AND HOSPICE BENEFITS		
Home Health (limited to 100 visits per Plan Year)	Covered at 100% after plan year deductible	Covered at 80% after plan year deductible
Skilled Nursing Facility	Covered at 100% after plan year deductible	Covered at 80% after plan year deductible
Hospice Care	Covered at 100% with deductible waived	Covered at 80% with deductible waived
PRESCRIPTION DRUG BENEFITS		
Retail Prescription Drugs: up to 30 day supply • **Tier 1 – Generic** • **Tier 2 – Preferred** • **Tier 3 – Non-preferred** • **Tier 4 – Specialty** **Over the Counter***	 $20 copay 50% copay, $75 maximum 50% copay, $125 maximum Not Covered $0 copay	
Mail Order Prescription Drugs: up to 90 day supply • **Tier 1 – Generic** • **Tier 2 – Preferred** • **Tier 3 – Non-preferred** • **Tier 4 – Specialty**	 $30 copay 50% copay, $150 maximum 50% copay, $250 maximum Not Covered	

Out-of-network expenses are subject to specific reasonable and appropriate terms as defined under Defined Terms/Definitions

*** Over-the-counter drugs include the following ulcer and allergy medications (must have physician's written prescription to fill the over-the-counter drug and must be processed using your prescription drug benefit card): Alavert, Allegra, Allegra-D, Axid AR, Cetirizine, Cimetidine, Claritin, Claritin- D, Dimetapp ND, Famotidine, Fexofenadine, Fexofenandine-Pseudophedrine, Loratadine, Nexium 24 hr OTC, Omeprazole, Pepcid Complete, Pepcid AC, Prevacid 24 hr Cap, Prilosec OTC, Ranitidine, Tagamet HB, Tavist ND, Triaminic Tab, Zantac, Zegerid OTC, Zyrtec, Zyrtec-D – name brands or store brands.**

If a service is not available at an independent facility and the service must be performed at a hospital, the independent facility co-pay will apply. Alternative Insurance Resources must receive pre-notification from the referring physician that the service is only available on an outpatient hospital basis.

NOTE: COVERED SERVICES OBTAINED FROM A NON-PPO PROVIDER WILL BE COVERED AT THE PPO BENEFIT LEVEL SUBJECT TO REASONABLE AND APPROPRIATE UNDER THE FOLLOWING CIRCUMSTANCES:

1. In the event treatment is for an accident or emergency medical condition inside or outside the PPO service area.
2. Certain ancillary services rendered at a PPO facility by a Non-PPO Provider, or services referred by a PPO provider or if services are not available from a PPO provider or facility.
3. Certain post-stabilization services rendered by a Non-PPO Provider (unless you provide written authorization to be balance billed for such services).

In the event a PPO scheduled fee is unavailable for the service provided, the Plan Administrator or designated vendor shall consider the Reasonable and Appropriate charge to be the maximum allowable charge for these Non-PPO provider's covered services.