

Belmont University 2010 Health Plan Summary

	Preferred Provider Plan		High Deductible Health Plan	
	In-network	Out-of-network	In-network	Out-of-network
Plan Features			All HDHP covered services shown below are covered at 100% after the out-of-pocket maximum has been met.	
Individual Deductible	\$400	\$800	\$1,200	\$2,400
Family Deductible	\$1,200	\$2,400	\$2,400	\$4,800
Hospital Confinement Deductible	N/A	\$500 deductible		
Individual Out-of-Pocket Limit	\$2,500	\$5,000	\$2,500	\$7,500
Family Out-of-Pocket Limit	\$5,000	\$10,000	\$5,000	\$15,000
Lifetime Limit	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Covered Services				
Physician Office Visits				
Routine Physical Examinations	\$20 PCP	50% after deductible	100% Preventative Only	50% after deductible
Preventive Care		Not covered		Not covered
Specialist (Office Visits)	\$30 specialist	50% after deductible	80% after deductible	50% after deductible
Outpatient Services				
Colonoscopy	100%	50% after deductible	100%	50% after deductible
Diagnostistic, Laboratory & X-Ray	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Outpatient Rehabilitation (in office)	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Physical Therapy				
Occupational Therapy				
Speech Therapy				
<i>100 total visits per calendar year</i>				
Spinal Manipulation (Chiropractic)				
<i>20 total visits per calendar year</i>				
Hospital Care	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Emergency Room & Ambulance Services				
Room and Board				
Diagnostic, Laboratory & X-Ray				
Miscellaneous Charges				
Professional Fees - Inpatient	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Surgeon/Physician				

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Maternity Care				
Physician Prenatal and Postnatal Care	Office visit copay	50% after deductible		50% after deductible
Inpatient Hospital	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Urgent Care Facility & Walk-in Clinic	\$30 copay	50% after deductible	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible	80% after deductible	50% after deductible
<i>Maximum</i>	\$10,000 annual maximum		\$10,000 annual maximum	
Home Health Care	80% after deductible	50% after deductible	80% after deductible	50% after deductible
<i>Maximum Visits per Year</i>	40 visits		40 visits	
Hospice Services	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Skilled Nursing/Extended Care	80% after deductible	50% after deductible	80% after deductible	50% after deductible
<i>Maximum Days per Year</i>	60 days		60 days	
Transplant Benefits	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Mental Health/Substance Abuse	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Prescription Drug Services				
Retail - 31 day supply				
Tier 1	\$10 copay	Not covered	80% after deductible	50% after deductible
Tier 2	\$25 copay	Not covered	80% after deductible	50% after deductible
Tier 3	\$45 copay	Not covered	80% after deductible	50% after deductible
Mail Order - 90 day supply			All Covered Prescriptions	
Tier 1	\$20 copay	Not covered	80% after Deductible	Not covered
Tier 2	\$50 copay	Not covered	& 100% after	Not covered
Tier 3	\$90 copay	Not covered	Out-of-Pocket Max	Not covered
Eye examinations	\$20 copay-must use Humana Provider	Not covered	\$50 Reimbursement through Ameritas	\$50 Reimbursement through Ameritas

Vision hardware from Ameritas	
Vision hardware reimburses based on the schedule shown below for either contacts or frames & lenses in the frequency allowance period.	
Frequency Allowance:	12 months
Frames	\$65.00
Lens per set:	
Single	\$40.00
Bifocal	\$60.00
Trifocal	\$75.00
No line bifocal or progressive	\$80.00
Lenticular	\$80.00
Contact Lenses	\$105.00