SCHEDULE OF BENEFITS

VERIFICATION OF ELIGIBILITY: Contact the Claims Supervisor to verify eligibility for Plan benefits **before** the charge is incurred. (Refer to General Plan Information section for contact information.)

PREADMISSION CERTIFICATION (also referred to as **PRECERTIFICATION**) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Utilization Review Coordinator will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to a Network Provider facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

PRECERTIFICATION REQUIREMENT: If any part of a Hospital or other Inpatient stay is not precertified per the instructions in the Cost Management Section, the benefit payment will be reduced by $200. A $100 penalty will be assessed for each unauthorized day of a precertified Inpatient stay.

The Plan may not, under state or Federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean delivery. (The Hospital stay begins at the time of delivery, or admission if the delivery occurred outside the Hospital.) The attending Physician does not have to obtain precertification from the Plan; however the Covered Person is still required to precertify the Hospital stay to avoid the above precertification penalty. (Refer to the Cost Management Services Section and Medical Benefits Section for complete details.)

PREAUTHORIZATION of certain services is requested and may expedite the adjudication of the claim. (For items marked with "*" in the "Schedule of Benefits – Medical" table, refer to the Cost Management Services Section for complete details.)

All Organ Transplant services, including evaluation, **must** be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator (Refer to General Plan Information section for contact information) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization.

TIMELY FILING OF CLAIMS: Claims must be filed with the Claims Supervisor within 365 days of the date charges for the services were incurred. If the Covered Person's coverage terminates, all claims must be filed within 90 days of the Covered Person's termination date. If the termination is due to death, the regular filing limit applies. If the Plan should terminate, all claims must be filed within 30 days of the Plan's termination date. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined. (Refer to the section entitled "How to Submit a Claim".)

MEDICAL BENEFITS

To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria:

(1) Medically Necessary;
(2) Ordered by an appropriate Physician;
(3) Not excluded under the Plan; and
(4) Meets the standards of care for the diagnosis.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the above. The meanings of these capitalized terms are in the Defined Terms section of this document.

PARTICIPATING PROVIDER ORGANIZATION (PPO)

The Plan is a plan which contains multiple Participating Provider Organizations.

Regional PPO for Southwest Missouri:	Mercy Health Network
Telephone:	(417) 820-9868 or if calling from outside the Springfield Missouri area (866) 732-4453
Web site:	http://mercyoptions.net
Regional Wrap PPOs, for outside the above area:	HealthLink and Freedom Network Select
Telephone:	800-624-2356
Web site:	www.healthlink.com and www.phpkc.com
National Wrap PPO, for outside the above areas:	First Health Network
Telephone:	800-226-5116
Web site:	www.firsthealth.com

Note: The utilization of these Wrap networks is not required. Refer to the exceptions listed below for when the higher Network Provider benefit is applied to services rendered by Wrap and Non-Network Providers.

Health and Wellness Center and Other On-Campus Academic Clinical Facilities: Eligible expenses incurred by Plan members who utilize the University's on-campus Health and Wellness Center and academic clinical facilities will be processed under the percentages delineated in the "**HEALTH and WELLNESS CENTER & OTHER ON-CAMPUS CLINICAL FACILITIES**" column on the "Schedule of Benefits-Medical". Plan members for whom this Plan is their primary insurance coverage, must assign Plan benefits for unpaid balances to be paid to Health and Wellness Center.

Other Contracted Providers: The Claims Administrator may also contract directly with certain Hospitals and Physicians. These providers will be considered Network Providers.

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. Network Providers are qualified medical professionals, however neither the Plan nor the network is responsible for damages caused by provider acts or failures to act. Accordingly, Covered Persons will have free choice of any legally qualified Physician or Other Professional Provider and the doctor/patient relationship will be maintained with any provider chosen.

A list of Network Providers is available by calling the PPO or searching for a provider on the PPO's web site. The phone number and web site are listed above and on your health care plan ID card. In order to obtain benefits at the higher level, it is the Covered Person's responsibility to make sure the provider is participating in the network prior to seeking services. Call the PPO to verify the current status of the provider before each visit.

CALCULATION OF THE ALLOWED AMOUNT UNDER THIS PLAN

Charges for services rendered by a Network Provider will be allowed at the Participating Provider Organization (PPO) contracted rate, negotiated rate or billed amount, whichever is less unless specifically stated otherwise in the contract with that provider or elsewhere in this Plan.

Charges for services rendered by a Non-Network Provider **without** an approved exception outlined below will be allowed at the Usual and Customary Allowance, Participating Provider Organization (PPO) contracted rate, negotiated rate or billed amount, whichever is less, and considered under the Non-Network Provider benefit (coinsurance amount and percentage differentials as listed in the following Medical Benefits Schedule table).

Charges for services rendered by a Non-Network Provider **with** an approved exception outlined below will be allowed at the negotiated rate, Usual and Customary Allowance or billed amount, whichever is less, and considered under the Network Provider benefit (coinsurance amount and percentage differentials as listed in the following Medical Benefits Schedule table).

Notwithstanding these allowances, all charges from all providers will be subject to a review for Reasonable allowance and never be allowed at a rate greater than billed charges.

The approved exceptions are as follows:

FOR COVERED PERSONS RESIDING WITHIN THE REGIONAL PPO NETWORK AREA:

- **WHEN SERVICES ARE RENDERED OUTSIDE THE NETWORK AREA it may be possible to receive the higher benefit:**

  - If a Covered Person requires services Incidental in nature. A referral is not required. The national PPO network is available but utilization of the network is not mandatory.

  - If a Covered Person has an Emergency Medical Condition (on an Inpatient or Outpatient basis) evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy or seriously impair bodily functions, bodily organs or parts. This applies to ambulance transport, facility and Physician charges. For an Inpatient admission, in order to continue to receive the higher benefit once the Covered Person's condition has been stabilized following admission to a Non-Network facility, the Covered Person must be transferred to a Wrap or Network facility.

  - If a Covered Person has no choice of a regional PPO Network Providers in the specialty required to treat the Illness or Injury. A referral is not required. Verification of the availability, or lack thereof, of a Network Provider must be submitted to the Utilization Review Coordinator by the Covered Person or the Physician to review for authorization of payment at the Network Provider benefit level prior to seeking services.

  - If a Covered Person is seeking services by a Wrap or Non-Network Provider when the services are available in the network area by a Network Provider, prior to seeking services, the Network Provider in that specialty must submit a referral to the Utilization Review Coordinator to determine if the services will be considered under the Network Provider benefit and the time period for which the services will be approved under this exception.

  - If a Covered Person is seeking services with a Mercy tertiary Network Provider in the Mercy extended PPO coverage area outside Southwest Missouri, a referral is required and must be submitted to the Utilization Review Coordinator for approval. If approved, the Network Provider benefit will apply.

  - If a Covered Person is admitted to a Network Provider facility on an Inpatient or Outpatient basis and receives Physician, diagnostic or anesthesia services by a Wrap or Non-Network Provider when a Network Provider in that specialty is not available.

  - If a Covered Person has a specimen for a lab test drawn or an x-ray taken by a Network Provider but a Wrap or Non-Network Provider performs the lab test or reads the x-ray.

  - If a Covered Person receives treatment, services or supplies by a Wrap or Non-Network Provider and the charges for the services were negotiated and/or approved by the Utilization Review Coordinator (refer to General Plan Information section for contact information). (Precertification is not an approval of the services or a guarantee of payment for the services.)

- **WHEN SERVICES ARE RENDERED WITHIN THE NETWORK AREA it may be possible to receive the higher benefit:**

  - If a Covered Person has no choice of a regional PPO Network Providers in the specialty required to treat the Illness or Injury. A referral is not required. The national wrap PPO network is available but utilization of the network is not mandatory. Verification of the availability, or lack thereof, of a Network Provider must be submitted to the Utilization Review Coordinator by the Covered Person or the Physician to review for authorization of payment at the Network Provider benefit level prior to seeking services.

  - If a Covered Person is seeking services by a Wrap or Non-Network Provider when the services are available by a Network Provider. Prior to seeking services, the Network Provider in that specialty must submit a referral to the Utilization Review Coordinator to determine if the services will be considered under the Network Provider benefit and the time period for which the services will be approved under this exception.

- If a Covered Person has an Emergency Medical Condition (on an Inpatient or Outpatient basis) evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy or seriously impair bodily functions, bodily organs or parts. This applies to ambulance transport, facility and Physician charges. For an Inpatient admission, in order to continue to receive the higher benefit once the Covered Person's condition has been stabilized following admission to a Non-Network facility, the Covered Person must be transferred to a Wrap or Network facility.

FOR COVERED PERSONS RESIDING OUTSIDE THE REGIONAL PPO NETWORK AREA:

- **WHEN SERVICES ARE RENDERED OUTSIDE THE REGIONAL NETWORK AREA, the Covered Person will receive the higher benefit:**
  - A referral is not required. The national Wrap PPO network is available but utilization of the network is not mandatory.

NOTES: Charges for services with discounts accessed through a repricing network in absence of any other exception listed above will be considered at the Non-**Network** ***Provider benefit level.***

The term "services", as used in this Plan document, means a recognized or standard medical service; it does not mean a specific technique, procedure or equipment. For example, hip replacement surgery would be considered a recognized or standard medical service; however, the specific technique used by the Physician, i.e., the manner of performing the surgery, is not considered as a service such as to qualify the Covered Person for an exception (as listed above) to the Wrap or Non-Network Provider reimbursement percentage.

Deductibles payable by Covered Persons

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that the Covered Person must pay once a Calendar Year before the Plan pays on any incurred Covered Charges. Beginning in January of each year, the deductible must again be met before Plan benefits are paid. Some services may have the deductible waived. Refer to the Schedule of Benefits for details.

Copayments payable by Plan Participants

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.

SCHEDULE OF BENEFITS - MEDICAL

(Refer to Medical Benefits Section for further details on each item listed.)
(Refer to the Cost Management Services Section for preauthorization on items marked with "*".)

<table>
<tr><th></th><th>HEALTH and WELLNESS CENTER & OTHER ON-CAMPUS CLINICAL FACILITIES</th><th>NETWORK PROVIDERS</th><th>NON-NETWORK PROVIDERS</th></tr>
<tr><td colspan="4">BASE PLAN</td></tr>
<tr><td colspan="4">DEDUCTIBLE, PER CALENDAR YEAR</td></tr>
<tr><td>Per Covered Person</td><td>Deductible Waived</td><td>$1,600</td><td>$3,200</td></tr>
<tr><td>Per Family Unit</td><td>Deductible Waived</td><td>$3,200</td><td>$6,400</td></tr>
<tr><td colspan="4">The Calendar Year deductible is waived for the following Covered Charges:
- Charges incurred at the Health and Wellness Center and other on-campus clinical facilities
- Second Surgical Opinion, Voluntary
- Routine Well Child and Well Adult Care (does not apply to Non-Network)</td></tr>
<tr><td colspan="4">MAXIMUM COINSURANCE AMOUNT, PER CALENDAR YEAR</td></tr>
<tr><td>Per Covered Person</td><td>$2,000</td><td>$2,000</td><td>$4,000</td></tr>
<tr><td>Per Family Unit</td><td>$4,000</td><td>$4,000</td><td>$8,000</td></tr>
<tr><td>Emergency Room Deductible</td><td>N/A</td><td>$500</td><td>$500</td></tr>
<tr><td colspan="4">Note: The Emergency Room Deductible is waived if the patient is admitted to the Hospital on an emergency basis directly from the emergency room or if treatment is substantiated by severity of the Sickness or Injury. The Utilization Review Coordinator, MPI Care, must be notified within 48 hours of a weekday admission and within 72 hours after an admission on a weekend or legal holiday even if the patient is discharged within the 48/72-hour period.</td></tr>
<tr><td>Medical Copayments</td><td></td><td></td><td></td></tr>
<tr><td>Primary Care Physician's & urgent care office visits:</td><td>$10</td><td>$40</td><td>N/A</td></tr>
<tr><td>Specialist's office visit:</td><td>$10</td><td>$60</td><td>N/A</td></tr>
<tr><td colspan="4">MAXIMUM MEDICAL COPAYMENTS AND ER DEDUCTIBLE AMOUNT, PER CALENDAR YEAR</td></tr>
<tr><td>Per Covered Person</td><td>$1,750</td><td>$1,750</td><td>No Maximum**</td></tr>
<tr><td>Per Family Unit</td><td>$3,500</td><td>$3,500</td><td>No Maximum**</td></tr>
<tr><td colspan="4">MAXIMUM MEDICAL OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</td></tr>
<tr><td>Per Covered Person</td><td>$3,750</td><td>$5,350</td><td>No Maximum**</td></tr>
<tr><td>Per Family Unit</td><td>$7,500</td><td>$10,700</td><td>No Maximum**</td></tr>
<tr><td colspan="4">The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.
The following charges do not apply toward the medical out-of-pocket maximum and are never paid at 100%:
- Cost containment penalties
- Prescription coinsurance through Pharmacies (percentage copayments)
- Charges excluded as ineligible, including amounts over Usual and Customary Allowance.
** When a Non-Network Provider is utilized, the Covered Person is responsible for any amounts over the Usual and Customary Allowance without this amount being applied toward the Maximum Out-of-Pocket amount.</td></tr>
<tr><td colspan="4">MAXIMUM PRESCRIPTION COINSURANCE AMOUNT, PER CALENDAR YEAR</td></tr>
<tr><td>Per Covered Person</td><td>$2,000</td><td>$2,000</td><td>$2,000</td></tr>
<tr><td>Per Family Unit</td><td>$4,000</td><td>$4,000</td><td>$4,000</td></tr>
<tr><td colspan="4">MAXIMUM MEDICAL & PRESCRIPTION OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</td></tr>
<tr><td>Per Covered Person</td><td>$5,750</td><td>$7,350</td><td>No Maximum **</td></tr>
<tr><td>Per Family Unit</td><td>$11,500</td><td>$14,700</td><td>No Maximum **</td></tr>
<tr><td colspan="4">Note: The maximum amounts an individual can contribute to the in-network deductible and coinsurance family maximums are amounts up to the Network "Per Covered Person" maximums. Therefore, if the individual has out-of-network services, only the amount up to the Network maximum will be counted toward reaching the family's Network maximum. For example, an individual has Non-Network Covered Charges of $3,200. $3,200 will be applied to the Non-Network deductible The individual Network deductible amount will be credited $1,600 for calculating their Network deductible and the family unit maximum.</td></tr>
</table>

	HEALTH and WELLNESS CENTER & OTHER ON-CAMPUS CLINICAL FACILITIES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
BUY-UP PLAN			
DEDUCTIBLE, PER CALENDAR YEAR			
Per Covered Person	Deductible Waived	$800	$1,600
Per Family Unit	Deductible Waived	$1,600	$3,200
The Calendar Year *deductible is waived* for the following Covered Charges: - Charges incurred at the Health and Wellness Center and other on-campus clinical facilities - Second Surgical Opinion, Voluntary - Routine Well Child and Well Adult Care (does not apply to Non-Network)			
MAXIMUM COINSURANCE AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$2,000	$2,000	$4,000
Per Family Unit	$4,000	$4,000	$8,000
Emergency Room Deductible	N/A	$250	$250
Note: The Emergency Room Deductible is waived if the patient is admitted to the Hospital on an emergency basis directly from the emergency room or if treatment is substantiated by severity of the Sickness or Injury. The Utilization Review Coordinator, MPI Care, must be notified within 48 hours of a weekday admission and within 72 hours after an admission on a weekend or legal holiday even if the patient is discharged within the 48/72-hour period.			
Medical Copayments			
Primary Care Physician's & urgent care office visits:	$5	$20	N/A
Specialist's office visit:	$5	$30	N/A
MAXIMUM MEDICAL COPAYMENTS AND ER DEDUCTIBLE AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$700	$700	No Maximum**
Per Family Unit	$1,400	$1,400	No Maximum**
MAXIMUM MEDICAL *OUT-OF-POCKET* AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$2,700	$3,500	No Maximum**
Per Family Unit	$5,400	$7,000	No Maximum**
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the medical out-of-pocket maximum and are never paid at 100%: - Cost containment penalties - Prescription coinsurance through Pharmacies (percentage copayments) - Charges excluded as ineligible, including amounts over Usual and Customary Allowance. ** When a Non-Network Provider is utilized, the Covered Person is responsible for any amounts over the Usual and Customary Allowance without this amount being applied toward the Maximum Out-of-Pocket amount.			
MAXIMUM PRESCRIPTION COINSURANCE AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$1,500	$1,500	$1,500
Per Family Unit	$3,000	$3,000	$3,000
MAXIMUM MEDICAL & PRESCRIPTION *OUT-OF-POCKET* AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$4,200	$5,000	No Maximum**
Per Family Unit	$8,400	$10,000	No Maximum**
Note: The maximum amounts an individual can contribute to the in-network deductible and coinsurance family maximums are amounts up to the Network "Per Covered Person" maximums. Therefore, if the individual has Non-Network services, only the amount up to the Network maximum will be counted toward reaching the family's Network maximum. For example, an individual has Non-Network Covered Charges of $1,600. $1,600 will be applied to the Non-Network deductible. The individual Network deductible amount will be credited $800 for calculating their Network deductible and the family unit maximum.			

	HEALTH and WELLNESS CENTER & OTHER ON-CAMPUS CLINICAL FACILITIES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
COVERED CHARGES			
Ambulance Service			
Emergency Medical Condition	Not applicable.	80% after deductible	60% after deductible (See when exceptions apply.)
Medical Non-Emergency Care	Not applicable.	80% after deductible	60% after deductible
***Applied Behavior Analysis for Autism Spectrum Disorders**	Not applicable.	80% after deductible	60% after deductible
		Limited to $44,760* paid per Calendar Year.	
Note: This benefit is for Dependent Children up to age 19. Refer to the Medical Benefit section for further details of this benefit. *The limit will be automatically updated based upon limit determined annually by MO DOI.			
Contact lenses or glasses	Not applicable.	80% after deductible	60% after deductible
Note: When required following eye surgery, except surgeries to correct refractive disorders. Refer to the Medical Benefit section for further details of this benefit.			
Diagnostic Testing	80%, deductible waived	80% after deductible	60% after deductible
Note: Includes X-rays, laboratory test, audiology tests, Pre-Admission Testing and diagnostic colonoscopies (symptomatic).			
***Durable Medical Equipment**	80%, deductible waived	80% after deductible	60% after deductible
Emergency Room Visit			
Emergency Medical Condition	Not applicable.	80% after deductible	60% after deductible (See when exceptions apply.)
Medical Non-Emergency Care	Not applicable.	80% after deductible	60% after deductible
***Home Health Care**	Not applicable.	80% after deductible	60% after deductible
		40 visits Calendar Year maximum	
Hospice Care	Not applicable.	80% after deductible	60% after deductible
		$10,000 Inpatient and Outpatient Lifetime maximum	
Bereavement Counseling (Immediate family only)	Not applicable.	80% after deductible	60% after deductible
		Three visits Lifetime maximum	
***Hospital Services**			
Room and Board	Not applicable.	80% after deductible	60% after deductible
		the facility's semiprivate room rate	
Newborn Nursery Care	Not applicable.	80% after deductible	60% after deductible
Note: Well Newborn charges will be considered under the benefits of the covered newborn.			
Intensive Care Unit	Not applicable.	80% after deductible	60% after deductible
		Hospital's ICU Charge	
Other Outpatient Services not listed herein	Not applicable.	80% after deductible	60% after deductible
Jaw Joint/TMJ	Excluded under Medical Plan. Refer to Dental Benefits.		
Mental Disorders			
Inpatient	Not applicable.	80% after deductible	60% after deductible
Outpatient and office visits	80%, deductible waived	80% after deductible	60% after deductible
***Organ Transplants**	Not applicable.	Designated Transplant Facility: 80% after deductible	Non-Designated Transplant Facility: 60% after deductible
Note: Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational". All Organ Transplant services, including evaluation, **must** be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization. Non-authorized services rendered by a non-designated transplant facility will be excluded by this Plan.			
***Orthotics**	80%, deductible waived	80% after deductible	60% after deductible
***Outpatient Private Duty Nursing**	Not applicable.	80% after deductible	60% after deductible
Physician Services			
Inpatient visits:	Not applicable.	80% after deductible	60% after deductible
Newborn Physician Care (Inpatient):	Not applicable.	80% after deductible	60% after deductible
Office visits:	100% after copayment	100% after copayment	60% after deductible
All other services in the Physician's office:	80%, deductible waived	80% after deductible	60% after deductible

	HEALTH and WELLNESS CENTER & OTHER ON-CAMPUS CLINICAL FACILITIES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Pregnancy	Not applicable	80% after deductible	60% after deductible
Note: Dependent daughters not covered. However, any pre-natal or maternity care that is required as Standard Preventive Care will be covered. Two ultrasounds will be considered eligible expenses for a routine Pregnancy for the following: to determine gestational age and for routine screening.			
Prescription Drugs (Inpatient, Outpatient & Physician's office)	80%, deductible waived	80% after deductible	60% after deductible
Preventive Care			
Routine Well Adult & Child Care			
ACA and Non-ACA Services, including immunizations after age 5:	100%, deductible waived.	100%, deductible waived	60% after deductible
Immunizations through age 5:	100%, deductible waived	100%, deductible waived	100%, deductible waived
ACA services are the recommended preventive services under the Affordable Care Act (ACA). The ACA follows services recommended by the United States Preventive Services Task Force (categories A and B), as well as recommendations and guidelines of the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA). A current listing of recommended preventive services under the Affordable Care Act can be accessed at www.HealthCare.gov/center/regulations/prevention.html.			
Note: This includes 1) screening/preventive care colonoscopies; 2) breast pumps (Refer to Medical Benefits, Routine Well Adult Care for breast pump coverage criteria. The Allowed Amount for the purchase through a Non-Network Provider will be no greater than $300.); and 3) quit smoking counseling/smoking deterrents (Smoking cessation counseling with a trained/certified therapist, counselor, healthcare provider or Physician. Prescription Drugs and over-the-counter treatments are eligible through the Prescription Drug Benefits. Contact the PBM for further information.)			
Non-ACA services are all other preventive services in conjunction with category "Routine" diagnosis codes in the current ICD book or are preventive/screening services not included in the ACA services. This will also include immunizations administered to prevent diseases such as yellow fever, typhoid, malaria, etc. in order to travel outside the United States (whether elective travel or for work-related travel) will be considered under this benefit. (Refer to Diagnostic Testing for coverage of colonoscopies required due to known symptoms.)			
Frequency limits for mammogram Ages 35 through 39 .... single Baseline mammogram Ages 40 and over .... annually			
***Prosthetics**	Not applicable.	80% after deductible	60% after deductible
Second Surgical Opinion, Voluntary	80%, deductible waived	100%, deductible waived	80%, deductible waived
Note: Refer to Cost Management Services section. Benefits for a second opinion for non-surgical services requires Utilization Review Coordinator approval.			
Skilled Nursing Facility	Not applicable.	80% after deductible	60% after deductible
		the facility's semiprivate room rate; within 14 days of a 3 day stay; 40 days Calendar Year maximum	
Spinal Manipulation/ Chiropractic Services	Not applicable.	80% after deductible	60%after deductible
		10 visits Calendar Year maximum	
Note: All services rendered by a chiropractor are subject to these maximums.			
Substance Abuse			
Inpatient	Not applicable.	80% after deductible	60% after deductible
Outpatient and office visits	80%, deductible waived	80% after deductible	60% after deductible
Teeth (replacement of)	Not applicable.	80% after deductible	60% after deductible
Note: This benefit is for the replacement of teeth removed for the medical management of a hazardous medical condition.			
Therapies			
*Cardiac Rehabilitation	80%, deductible waived	80% after deductible	60% after deductible
*Occupational Therapy	Not applicable.	80% after deductible	60% after deductible
*Physical Therapy	80%, deductible waived	80% after deductible	60% after deductible
*Pulmonary Rehabilitation	80%, deductible waived	80% after deductible	60% after deductible
*Speech & Audiologist Therapy	80%, deductible waived	80% after deductible	60% after deductible
Vision Therapy	80%, deductible waived	80% after deductible	60% after deductible

	HEALTH and WELLNESS CENTER & OTHER ON-CAMPUS CLINICAL FACILITIES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
***Weight Management** (Obesity Treatment)	80%, deductible waived	80% after deductible	60% after deductible
Note: Refer to Medical Benefits section for further details on what is covered under this benefit.			
Wigs	Not applicable.	80% after in-network deductible One wig Lifetime maximum; up to $300 paid maximum.	
Note: Refer to Medical Benefits section for coverage criteria.			
All other Covered Charges not excluded or limited in this Plan Document:	80%, deductible waived	80% after deductible	60% after deductible

SCHEDULE OF BENEFITS
PRESCRIPTION DRUGS
(DISPENSED AT A PHARMACY)

PRESCRIPTION DRUG BENEFIT All prescriptions should be filed through the Pharmacy Benefit Manager (PBM)			
	HEALTH and WELLNESS CENTER PHARMACY	**NETWORK PHARMACY**	**NON-NETWORK PHARMACY**
Retail Prescriptions- (Per 30-day supply)			
Generic Drugs	20% coinsurance	30% coinsurance	(See Note below.)*
Brand Name Drugs	20% coinsurance	30% coinsurance	(See Note below.)*
Mail Order or Network MedTrak 90 Retail Pharmacy Network- (Per 90-day supply)			
Generic Drugs	N/A	30% copayment	(See Note below.)*
Brand Name Drugs	N/A	30% copayment	(See Note below.)*
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Covered Person	Base Plan: $2,000; Buy-Up Plan: $1,500		
Per Family Unit	Base Plan: $4,000: Buy-Up Plan: $3,000		

Note: Medications that are preventive care services under the Affordable Care Act will be covered at 100% and not require a copayment. This includes all Generic and certain Brand Name oral contraceptives, aspirin, certain vitamins and supplements, smoking deterrents, certain vaccinations/immunizations, etc. Contact the PBM for further details.

Generic Incentive:

Covered Expenses will be limited to the cost of a Generic drug if an equivalent Generic drug is available when a Multi-source Brand Name drug is dispensed. In addition to the coinsurance, the Covered Person must pay the difference between the cost of the Generic drug and the Multi-source Brand Name drug.

Prior authorization is required for any prescription over $1,000 (30-day) or $2,000 (90-day).

Specialty Drugs treat multi-faceted chronic diseases. They typically require unique clinical, administration, distribution and handling requirements. They are more expensive than traditional prescriptions and there are limited generics and biosimilars available. Biosimilars are a potential future opportunity that will provide therapeutic options for already approved specialty brand drugs at potentially lower costs. A list of these drugs is available by contacting the Claims Supervisor or Pharmacy Benefit Manager as stated on your health plan ID card.

Filing for a Prescription Drug Benefit reimbursement when a Non-Network Pharmacy is used or when the Pharmacy Card is not used:

If this is your primary plan, all prescriptions should be filed through the Pharmacy Benefit Manager (PBM). If the Pharmacy charges less than the discount price available through the PBM, you may purchase the prescription without the card and submit the receipt along with a claim form to the PBM and state the situation on the form.

The reimbursement (based upon the PBM allowance less a small processing fee) will be sent to the Covered Employee. Some exceptions to the PBM allowance may be made for extenuating circumstances. Typically, a Pharmacy can refile a claim within 14 days if a problem existed in filing the claim electronically. The PBM help desk is available six days a week to assist the Pharmacy with rejected claims.

If this is your secondary plan, submit your receipt and/or explanation of benefits from your primary plan to Med-Pay. The coordination of benefits provision applies and benefits are payable under this Prescription Plan. The billed amount will be the amount listed on the receipt (total amount allowed or copayment, if total allowed is not listed). This Plan will pay prescription drug benefits as primary for any Active Employee who is also Medicare eligible.

Contact the PBM (see your ID card) for any questions about what drugs are covered under this Plan.

Claim forms may be obtained on the Missouri State University website.