



SCHEDULE OF BENEFITS

Plan R

Please refer to the Schedule of Benefits issued to the primary covered person. The member identification number and effective date of coverage are printed on the personalized Schedule of Benefits.

Inpatient admissions require Pre-certification. The telephone number to call for Pre-certification is listed on Your identification card.

Covered Expenses for an assistant surgeon, emergency room Physician, lab, x-ray, or anesthesia rendered by a Non-Network provider at a Network facility will be covered at the Network benefit level. When services that are Covered Expenses are performed by a Non-Network provider outside the Covered Person's control or election such services will be covered at the Network benefit Level.

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT		
Maximum Benefit Amount	Unlimited	
DEDUCTIBLE, PER PLAN YEAR		
Per Individual	\$0	\$500
Per Family Unit	\$0	\$1,000
COINSURANCE PERCENTAGE PAYABLE		
Percentage payable by the Plan	50%	30%
Percentage payable by the Individual	50%	70%
COINSURANCE OUT-OF-POCKET MAXIMUM, PER PLAN YEAR (Excludes Deductible)		
<small>Network and Non-Network Coinsurance out-of-pocket maximums are independent of each other.</small>		
Per Individual	\$3,500	\$7,000
Per Family Unit	\$7,000	\$14,000
MEDICAL BENEFITS		
Physician Services		
Office Visit (Primary Care Physician)	50%	30% after Deductible
Specialist Office Visits	50%	30% after Deductible
Allergy Testing and Treatments	50%	30% after Deductible
Spinal Manipulations/Chiropractic Care o Plan Year maximum limit: 26 visits	50%	30% after Deductible
Surgery - Inpatient & Outpatient	50%	30% after Deductible

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Urgent Care	50%	30% after Deductible
Hospital Room & Board (Pre-certification required) <ul style="list-style-type: none"> o Hospital Room and Board payment rate is the semiprivate room rate o Intensive Care Unit payment rate is the Hospital's ICU rate o Copay is per admission & does not apply to Deductible or Coinsurance 	\$250 Copay then paid 50%	\$250 Copay, then paid 30% after Deductible
Emergency Room – Medical Emergency <ul style="list-style-type: none"> o Copay waived if admitted o Copay does not apply to the Deductible or Coinsurance out-of-pocket maximum 	\$75 Copay, then paid 50% Deductible waived	
Emergency Room – Non-Emergency <ul style="list-style-type: none"> o Copay does not apply to the Deductible or Coinsurance out-of-pocket maximum 	\$75 Copay, then paid 50%	\$75 Copay, then paid 30% after Deductible
Skilled Nursing Facility (Pre-certification required) <ul style="list-style-type: none"> o Plan Year maximum limit: 60 days 	50%	30% after Deductible
Ambulance Service	50% Deductible waived	
Durable Medical Equipment <ul style="list-style-type: none"> o Equipment must be Medically Necessary 	50%	30% after Deductible
Home Health Care <ul style="list-style-type: none"> o Plan Year maximum limit: 60 visits 	50%	30% after Deductible
Hospice Care (Inpatient Hospice requires Pre-certification)	50%	30% after Deductible
Maternity Benefits	50%	30% after Deductible
Member Assistance Program (MAP) <ul style="list-style-type: none"> o Plan Year maximum limit: 3 visits o Through New Directions www.ndbh.com 	Covered 100% by MAP	N/A
Organ Transplants (Pre-certification required) <ul style="list-style-type: none"> o Inpatient confinements subject to a \$250 Copay per admission o Copay does not apply to the Deductible or Coinsurance out-of-pocket maximum o Covered transplants: <ul style="list-style-type: none"> ▪ Bone Marrow, Lung, Kidney, Heart, Pancreas & Liver o Donor charges are covered when the recipient is a Covered Person 	50%	Not covered
Outpatient Diagnostic Tests	50%	30% after Deductible
Outpatient Rehabilitation Therapies Cardiac Rehabilitation, Neuropsychological Testing, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitative Services & Speech Therapy	50%	30% after Deductible

BENEFIT CATEGORY	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Preventive Care <ul style="list-style-type: none"> o Preventive Care includes such services as an annual physical exam, mammogram, Pap smear, PSA screening, colorectal cancer screening, immunizations, and preventive x-ray and lab screenings o Limitations may apply based on age and frequency <p>See Your Plan Document for more detailed information about Preventive Care Services.</p>	100%	Not covered
Newborn Nursery Care <ul style="list-style-type: none"> o Care while the newborn is Hospital confined after birth, charged to the Plan of the newborn o Newborn must be enrolled within 31 days of birth 	50%	30% Deductible waived
Prosthetic Devices	50%	30% after Deductible
Second & Third Surgical Opinions <ul style="list-style-type: none"> o A third opinion is covered if the second opinion does not support surgery 	50%	30% after Deductible
Sterilizations (Reversals Excluded)	50%	30% after Deductible
Mental/Nervous Disorders & Substance Abuse Treatments		
Inpatient (Pre-certification required) <ul style="list-style-type: none"> o Copay is per admission & does not apply to Deductible or Coinsurance 	\$250 Copay, then paid 50%	\$250 Copay, 30% after Deductible
Partial Day	50%	30% after Deductible
Outpatient Office Visits	50%	30% after Deductible
All Other Covered Expenses	50%	30% after Deductible
OUTPATIENT PRESCRIPTION DRUG CARD BENEFIT		
Retail Pharmacy - (Up to a 34-day supply)	Member Pays	Reimbursement is at the Network <u>allowable cost</u> for the drug. You may have higher out-of-pocket expenses if you use a Non-Participating Pharmacy
Generic Copay	35% up to \$50	
Formulary Copay	45% up to \$100	
Non-Formulary Copay	50% up to \$150	
Specialty Drug Copay <ul style="list-style-type: none"> o Prior authorization required 	50% up to \$200	
MedTrak 90 Program – (Up to a 90 day supply)	Member Pays	Not applicable
Generic Copay	35% up to \$100	
Formulary Copay	45% up to \$200	
Non-Formulary Copay	50% up to \$300	
<p>The MedTrak 90 program allows a Covered Person to purchase a 90-day supply of Non-Specialty medications at a local, MedTrak 90 retail Pharmacy.</p> <p>Maximum out-of-pocket for Outpatient Prescription Drugs purchased through the retail drug card program is \$1,500 per Covered Person per Plan Year.</p>		
Mail Order Maintenance Medications – through Walgreens Mail Pharmacy		
(Up to a 90 day supply)	Member Pays	Not applicable
Generic Copay	\$20	
Formulary Copay	\$60	
Non-Formulary Copay	\$100	

Prescription Copays do not apply to the Medical Expense Deductible or out-of-pocket maximum.

Insulin, hypodermic needles/syringes/pen needles, test strips and lancets are Covered Expenses under the Prescription Drug Card when dispensed with a written prescription. When insulin and hypodermic needles/syringes/pen needles are purchased at the same time, there will be one combined Copay. The Mail Order Prescription Drug Program is also available for ordering of insulin and hypodermic needles/syringes/pen needles.

Generic Program – If a Generic equivalent is available, then that equivalent is the benefit. If the patient or Physician, for whatever reason, demands the more expensive branded product be dispensed, the patient pays in addition to the appropriate Copay, the difference in cost between the generic and branded product.

Formulary Brand drugs are defined as those drugs listed on the MedTrak Services National Formulary. The National Formulary is a list of clinically approved, cost-effective products. The National Formulary can be viewed at www.medtrakservices.com.

Non-Formulary drugs are similar drugs that are considered to be less cost effective than the preferred products. Non-Formulary drugs may have either a generic equivalent or lower cost brand name available, or may not be targeted on the National Formulary.

Specialty Drugs are high-cost, complex pharmaceuticals (usually injectable) that have unique clinical, administration, distribution, or handling requirements that are not commonly available in traditional community and mail-order pharmacies.

Prior Authorization is required for all Specialty Drugs. In addition, select medications must be filled through a Preferred Specialty Pharmacy. Contact MedTrak Services at (800) 771-4648 to locate a Specialty Pharmacy through the Plan's Pharmacy Benefit Manager.

Step Therapy Program – Many prescriptions are available in a Generic form. Generic drugs reduce Plan costs and should be tried first before purchasing a Brand Name drug. The Step Therapy Program requires a participant to try a Generic Step One drug prior to obtaining a Step Two drug. Step Therapy drugs involve the following classifications:

Antidepressants	Anti-Arthritics	Nasal Steroids
Proton Pump Inhibitors	Lipid Lowering Agents	Bisphosphonates
Anti-Hypertensives	Sedative Hypnotics	Alpha 1 Blockers
Muscle Relaxants	Triptans	

Examples:

- Patient must try generic Ambien before Ambien CR.
- Patient must try a generic of Zocor, Pravachol or Mevacor before Lipitor.
- Patient must try generic Prilosec, PrilosecOTC, or Generic Protonix before Nexium or Aciphex.

Contact MedTrak Services at (800) 771-4648 if You have questions about the Step Therapy Program.

This Schedule of Benefits and the Midwest Public Risk Plan Document are your contract for coverage. All limitations, exclusions and Plan provisions explained in the Plan Document apply to the benefits described in the Schedule of Benefits. The Plan Administrator and the delegates, where responsibility has been delegated to others, shall have complete authority to determine the standard of proof required in any case and to apply and interpret the Schedule of Benefits and Plan Document.