WEST NOBLE SCHOOL CORPORATION
SCHEDULE OF MEDICAL BENEFITS
Plan 2 Alternative

	P.P.O. NETWORK	NON-NETWORK
Calendar Year Deductible	$ 6,200 Single Coverage	No Coverage
	$12,400 Family Coverage	No Coverage
Hospital Pre-Certification Program Refer to Section II	The plan requires that prior to any elective or scheduled Hospital confinement, Outpatient Imaging for MRI's CAT Scans, PET Scans, SPECT Scans and Outpatient Surgery the employee or his Physician must obtain pre-certification by calling the phone number on the I.D. card (within 2 workdays of an emergency or weekend Hospital admission). Failure to have any Inpatient Hospital admission pre-certified will result in a penalty of $250 per admission. This penalty will be waived for all outpatient procedures.	
Lifetime Maximum	Unlimited	

	P.P.O. NETWORK	NON-NETWORK
Maximum Out-of-Pocket (Including the Deductible)		Unlimited
Single Coverage	$ 6,850	
Family Coverage	$13,700	Unlimited
Room and Board and Miscellaneous Charges	40% of Eligible Expenses subject to the deductible.	Not Covered
Surgery (Doctor charges)	40% of Eligible Expenses subject to the deductible.	Not Covered
Doctor Office Visits	40% of Eligible Expenses subject to the deductible.	Not Covered
Preadmission Testing	40% of Eligible Expenses not subject to the deductible.	Not Covered
Emergency Room Charges	$800 co-pay after the deductible	$800 Co-pay Per Visit
Urgent Care Centers	$150 Co-pay Per Visit subject to the deductible.	$150 Co-pay Per Visit

	P.P.O. NETWORK	NON-NETWORK
X-Ray/Lab Charges	40% of Eligible Expenses subject to the deductible.	Not Covered
Surgery Performed At Doctor's Office (Includes Doctor Charges)	40% of Eligible Expenses subject to the deductible	Not Covered
Facility and Doctor Charges (Other Than in Doctor's Office)	40% of Eligible Expenses subject to the deductible	Not Covered
Services Received in a Network Facility	If a covered person goes to a Network Facility and receives care and treatment by a Provider that is not of his choice and is not part of the Network, those charges will be reimbursed as if rendered by a Network Provider.	
Drug Card/Mail Order Program	4D Pharmacy / Magellan PHARMACY / WELLDYNERX	

Co-Payment Per Prescription

Retail Pharmacy 1-30 day supply
- Generic - $60.00
- Formulary Brand - $120.00
- Non-Formulary Brand – 40% after the deductible

Retail Pharmacy 31-90 day supply
- Generic - $150.00
- Formulary Brand - $300.00
- Non-Formulary Brand – 40% after the deductible

Mail Order 1-90 day supply
- Generic - $150.00
- Formulary Brand - $300.00
- Non-Formulary Brand – 40% after the deductible

The plan only pays a generic benefit when a brand medication is purchased that has a generic available. Member will be responsible for the cost difference between the brand and generic product, plus the applicable copay even if the doctor requires that a brand medication be filled when a generic is available.

NOTE: Injectable medications (other than products like insulin, epi-pens, etc.) are not covered under the prescription benefit. They may be covered under major medical coverage.

Include DAW 1 and 2 edits at retail and mail order as part of the program.

	P.P.O. NETWORK	NON-NETWORK
Mental Illness		
Inpatient Facility	40% of Eligible Expenses, subject to the deductible.	Not Covered
Outpatient Visits	$100 Co-Pay Per Visit	Not Covered
Substance Abuse		
Inpatient Facility	40% of Eligible Expenses, Subject to the deductible	Not Covered
Outpatient Visits	$100 Co-Pay Per Visit	Not Covered
Wellness Benefit: Preventive Screenings and Immunizations	No Charge Paid 100% not subject to a deductible	Not Covered

OTHER BENEFITS

	P.P.O NETWORK	NON-NETWORK
Ambulance Service	$500 Co-pay after the deductible	Not Covered
Emergency Medical Treatment	In the event medical treatment, or for participants living outside of the network area, expenses will be considered and paid as an IN-Network expense. This provision will apply whether any or all providers are part of the PPO Network. This provision will also apply in the event transfer of the patient to another out of network facility is necessary in order to properly treat the patient. This provision will not apply for any participant who elects to travel outside of the PPO network in order to seek medical treatment.	
Medical Aids	40% of Eligible Expenses subject to the Deductible	Not Covered
Infertility Treatment	Not Covered	Not Covered
Second Surgical Opinion	40% of Eligible Expenses subject to the Deductible	Not Covered

Temporomandibular Joint Dysfunction (TMJ)	Not Covered	Not Covered
Home Health Care	40% of Eligible Expenses subject to the Deductible	Not Covered
Hospice Care	40% of Eligible Expenses subject to the deductible.	Not Covered
Skilled Nursing Facility	40% of Eligible Expenses subject to the deductible.	Not Covered
Organ Transplant Expense Benefit	40% of Eligible Expenses Subject to the deductible. Organ transplants considered experimental in nature are excluded under the plan, and eligible donor expenses are limited to a maximum payment of $5,000.	Not Covered
Chiropractic Services	Not Covered	Not Covered
Supplemental Accident Benefit	Not Covered	Not Covered