

The following text is the "Benefit Summary" for the Drake University Point of Service Health Plan.

**DRAKE UNIVERSITY POINT OF SERVICE HEALTH PLAN  
BENEFIT SUMMARY**

Administered by First Administrators, Inc.

**Group #: 92400**

Effective Date: June 1, 2007

All benefits are subject to the following deductibles, coinsurance percentages and maximums unless otherwise stated

MEDICAL BENEFITS	PATIENT'S LIABILITY		GENERAL PLAN LIMITS	PAGE
	NETWORK PROVIDER	NON NETWORK PROVIDER		
<b>Medical Deductible:</b>  - Per Individual/CAL YR - Per Family/CAL YR	\$250 \$500	\$1000 \$2000	No fourth quarter carryover. The deductible is waived when an Office Services Co-Pay is taken. <i>The Network and Non-Network deductibles are mutually exclusive.</i>	
<b>Out-of-Pocket Maximums:</b>  - Per Individual/CAL YR - Per Family/CAL YR	\$1250 \$2500	\$2500 \$5000	<b>Includes</b> Calendar Year Deductibles, Co-Pays and Coinsurance amounts. <b>Excludes</b> Hospital Preadmission Certification Penalty, Mental Health and Chemical Dependency benefits, Vision hardware, and Prescription Drug Program Co-Pays. <i>The Network and Non-Network out-of-pocket maximums are mutually exclusive.</i>	
<b>Office Services Co-Pay**</b>	\$15 per visit	\$30 per visit	Co-Pay applies with or without office visit charges. Co-Pay is waived for Preventive Care services and Well-Baby/Well-Child Care. After Non-Network Co-Pay, Non-Network services may be subject to balance billing.	
<p><b>** Except:</b> Anesthesia; Cardiac Rehabilitations; Diabetic Self-Management Education Program; Chemotherapy; Interpretations (which are separate from an office visit); Occupational Therapy; Physical Therapy; Radiation Therapy; Respiratory/Inhalation Therapy; Speech Therapy; Preventive Care Benefits (Routine and Well-child Care) and Mandatory Second Surgical Opinions.</p> <p><b>Note:</b> The Office Services Co-Pay will apply to providers rendering services in an outpatient or ambulatory facility if the physician does not have a local office.</p>				
<p><b>NETWORK NOTES:</b></p> <ol style="list-style-type: none"> <li>When a covered participant is referred by a <b>Network</b> provider to a <b>Non-Network</b> provider, eligible expenses for the <b>Non-Network</b> provider will be considered at the <b>Network</b> benefit level.</li> <li>When a covered participant is assigned to the Beech Street Network and sees a Select First provider, eligible expenses will be considered at the <b>Network</b> benefit level.</li> <li>When a covered participant resides outside the <b>Network</b> area, or is traveling outside the <b>Network</b> area for reasons other than medical care (e.g., business or vacation), and a <b>Non-Network</b> provider is used, eligible expenses from the <b>Non-Network</b> provider will be considered at the <b>Non-Network</b> benefit level.</li> <li>Services and/or treatment provided by a <b>Non-Network</b> provider when there is no <b>Network</b> provider available within the <b>Network</b> area will be considered at the <b>Network</b> benefit level.</li> <li>If a participant requires treatment for a medical emergency, and is unable to see a <b>Network</b> provider, eligible expenses from a <b>Non-Network</b> provider will be considered at the <b>Network</b> benefit level.</li> <li><b>Non-Network</b> emergency room physician charges will be considered at the <b>Network</b> benefit level when services are provided in a <b>Network</b> facility.</li> <li>Ancillary services provided by a <b>Non-Network</b> provider in a <b>Network</b> facility will be considered at the <b>Network</b> benefit level.</li> <li>Interpretation of x-ray and laboratory results ordered by a <b>Network</b> provider and provided by a <b>Non-Network</b> provider will be considered at the <b>Network</b> benefit level.</li> <li>Charges for interpretation of x-ray or laboratory services performed in an independent radiology or pathology facility and billed by the <b>Network</b> physician ordering the services will be considered in the same manner as any other x-ray or laboratory service performed in a <b>Network</b> provider's office.</li> </ol> <p><b>The eligible expense for all of the above situations, unless otherwise specified, is determined by the provider and type of service, not the benefit level, as explained under the <i>What Are Covered Expenses?</i> Section. The eligible expense is based on the Network fee schedule or discount, the maximum allowable fee, or the actual amount charged.</b></p>				-

**BENEFIT SUMMARY (Cont.)**

<b>Utilization Review:</b>	The Utilization Review program includes Preadmission Certification, Pre-procedure Review, Prenatal Screening Program and Case Management administered by First Administrators, Inc.
<b>Preadmission Certification:</b>	Failure to comply with the Hospital Preadmission Certification provision will result in a \$500 penalty applied to hospital-related inpatient charges. Pre-certification must take place prior to a planned admission or within two business days following an emergency admission. The Preadmission Certification penalty is waived for maternity lengths of stay of less than 48 hours for normal vaginal delivery and 96 hours for a cesarean section. Penalties do not apply to out-of-pocket maximums.
<b>Pre-Procedure Review:</b>	Specified surgical procedures performed without pre-procedure review will result in a \$500 non-compliance penalty. The non-compliance penalty will not apply to out-of-pocket maximums. See Pre-Procedure List.

**If applicable, Office Services Co-Pay will apply to all the following benefits unless there is a separate Co-Pay indicated below.**

MEDICAL BENEFITS	NETWORK PROVIDER	NON NETWORK PROVIDER	GENERAL PLAN LIMITS	PAGE
Allergy Testing and Injections	80%	70%	<b>Includes</b> injections, testing, and serum. Injections covered at 100% if the purpose of the office visit is for an injection only.	
Ambulance Benefits	100%	100%	Limited to local air or ground.	
Ambulatory/Outpatient Surgery Facility Care	80%	70%		
Anesthesia	80%	70%	<b>Includes</b> anesthesia administered by a CRNA.	
Biologically Based Mental Illness	80%	70%		
Birthing Center Care Benefits	80%	70%		
Cardiac Rehabilitation	80%	70%	Limited to phase I (inpatient) and phase II (outpatient) treatment only; phase III treatment (diet, exercise, healthy lifestyle programs) is excluded.	
Chiropractic Services (Manual/Mechanical Manipulation of Spinal Column)	80%	70%	<b>Includes</b> Manipulation, x-rays, and office visits.	
Consultations - Inpatient - Outpatient	80% 80%	70% 70%		
Contraceptive Management Benefits	80%	70%	Includes injectable contraceptives (e.g., Depo-Provera), implantable contraceptives (e.g., Norplant), contraceptive device (e.g., IUD), and surgical removal of contraceptives.	
Dental Services Under The Medical Plan	80%	70%	Limited to services provided within 6 months of accidental injury.	
Diabetic Self-Management Program	80%	70%		
Diagnostic X-ray & Laboratory Benefits – Outpatient	80%	70%		
Durable Medical Equipment	80%	70%	Prior approval is recommended. Rental limited to purchase price.	

**BENEFIT SUMMARY (Cont.)**

<b>MEDICAL BENEFITS</b>	<b>NETWORK PROVIDER</b>	<b>NON NETWORK PROVIDER</b>	<b>GENERAL PLAN LIMITS</b>	<b>PAGE</b>
Emergency Room Services	80%	70%		
Hemodialysis (Kidney Disease Treatment)	80%	70%		
Home Health Care Benefits	80%	70%	Prior approval is recommended. Limited to 100 visits per calendar year.	
Home Infusion	80%	70%	Prior approval is recommended.	
Hospice Care Benefits - Inpatient - Outpatient - Respite Care - Bereavement	80% 80% 80% 80%	70% 70% 70% 70%	Prior approval is recommended.  Subject to Case Management approval. Limited to services provided by the Hospice provider.	
Hospital Benefits	80%	70%	Limited to the semi-private room rate for the level of care the patient is receiving. <b>Includes</b> hospital take home drugs.	
Infertility	80%	70%	Limited to employee, covered spouse or covered domestic partner. Limited to \$30,000/lifetime/participant (includes prescription drugs). <b>Includes</b> reversal of elective sterilization.	
Maternity Benefits - Inpatient Newborn Care	80%	70%	Payable for all female participants. Paid as part of mother's charges as long as mother is necessarily confined. <b>Includes</b> nursery room and board, physician visits and circumcision.	
Mental Health and Chemical Dependency Benefits  - Inpatient  - Outpatient  - Office	 80%  80%	 70%  70%	Chemical Dependency treatment is limited to \$200,000 per lifetime. Participant coinsurance amounts do not apply to the out-of-pocket maximum.  <b>Includes</b> Partial Hospitalization (1 day = 1 inpatient day) Limited to 30 days per calendar year.  Outpatient/Office limited to 50 visits per calendar year.  Subject to Office Services Co-Pay.	
Morbid Obesity	80%	70%	<b>Excludes</b> weight loss classes.	
Nursing Facility Benefits	80%	70%	Limited to semi-private room rate. Limited to 120 days per illness or injury. Services must follow a hospital stay of 3 days or more and begin no later than 14 days following that inpatient stay.	

**BENEFIT SUMMARY (Cont.)**

<b>MEDICAL BENEFITS</b>	<b>NETWORK PROVIDER</b>	<b>NON NETWORK PROVIDER</b>	<b>GENERAL PLAN LIMITS</b>	<b>PAGE</b>
Physician Services - Inpatient  - Outpatient	100%  100%	70%  70%	Limited to one visit per day per specialty unless additional visits are medically necessary.	
Preadmission Testing - Outpatient	80%	70%		
Prescription Drugs	80%	70%	<b>Includes</b> only those allowable drugs, medications and supplies that are not payable under the Prescription Drug Card.	
Preventive Care Services	100%	100%	Limited to \$500 per calendar year for participants age 7 and older. The Office Services Co-Pay and Plan Deductible do not apply for benefits \$500 and less. Eligible charges exceeding \$500 will be subject to the Office Services Co-Pay, Deductible and Coinsurance. There is no limit on the benefits paid for Preventive Services in excess of \$500.  <b>Includes:</b> - physician office visit - examinations - mammogram - routine x-ray/lab - immunizations - cancer screenings - prostate screenings - services for screening of "family history of" - pap smears - office visits for contraceptive management - routine hearing exams - vision examinations ( including eyewear exam) - three (3) nutritional counseling visits/CAL YR	
Private Duty Nursing	80%	70%		
Prosthetic Devices	80%	70%	<b>Includes</b> artificial limbs and eyes, hip prosthesis, lens implant following cataract surgery and breast implants following a mastectomy. Limited to one per lifetime unless medically necessary due to circumstances such as physical growth.	
Radiation Therapy and Chemotherapy	80%	70%		
Second/Third Surgical Opinion - Mandatory  - Voluntary	100%  100%	100%  100%	Limited to opinions <b>required</b> by the Pre-procedure Review program. Limited to opinions <b>required</b> by the Pre-procedure Review program.	
Surgical Benefits - Inpatient - Outpatient - Assistant Surgeon	80% 80% 80%	70% 70% 70%	Limited to 20% of the eligible expense for the primary surgery.	
Therapy Benefits (Outpatient) - Respiratory/Inhalation Therapy - Occupational Therapy - Speech Therapy - Physical Therapy	80% 80% 80% 80%	70% 70% 70% 70%	<b>Excludes</b> occupational therapy supplies.	

**BENEFIT SUMMARY (Cont.)**

<b>MEDICAL BENEFITS</b>	<b>NETWORK PROVIDER</b>	<b>NON NETWORK PROVIDER</b>	<b>GENERAL PLAN LIMITS</b>	<b>PAGE</b>
Transplant Benefits - Meals/Lodging/Travel	80% 100%	70% 100%	<b>Includes</b> heart, heart/lung, liver, pancreas, kidney, bone marrow and cornea. Limited to \$10,000 per transplant. Travel, meals, and lodging for the recipient and a companion will be covered if the transplant facility is more than 100 miles from the recipient's home. This benefit does not include ambulance expenses for the covered recipient.	
Urgent Care	80%	70%		
Vision Hardware Benefits	80%	80%	The calendar year deductible is waived. Participant coinsurance amounts do not apply to the out-of-pocket maximum. Limited to \$150 per calendar year. <b>Includes</b> eyeglass frames, lenses, and contact lenses.	
Well-Baby/Well-Child Care	100%	100%	Limited to children up to age 7. Office Services Co-Pay and Deductible is waived. <b>Includes</b> routine exams, routine labs/x-rays, immunizations, nutritional counseling, and one eye exam per calendar year.	
<b>MEDICAL PLAN'S MAXIMUM LIABILITY</b>				
<b>Lifetime Maximum</b>	\$3,000,000			
<b>Claims must be received within 12 months of the date services were incurred.</b>				

**PRESCRIPTION DRUG CARD PROGRAM BENEFITS**

<b>PRESCRIPTION DRUG BENEFITS</b>	<b>PATIENT'S LIABILITY</b>	<b>GENERAL PLAN LIMITS</b>	<b>PAGE</b>
Stand-alone Drug Program  Prescription Drug Card - Generic - 30-day supply - 60-day supply - 90-day supply  - Brand Name - 30-day supply - 60-day supply - 90-day supply	          \$10 Co-Pay \$20 Co-Pay \$30 Co-Pay  the lesser of 30% or \$50 the lesser of 30% or \$100 the lesser of 30% or \$150	Maintenance drugs can be purchased in a 60-day or 90-day supply at retail pharmacies. Maintenance drugs can be purchased in a 90-day supply through the mail order pharmacy program.	

**Drake University**