CITY OF MONROE
SCHEDULE OF BENEFITS
EFFECTIVE JULY 1, 2014

Verification of Eligibility 704 525-9666 or 800 347-1232

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Hospitalizations
Skilled Nursing Facility stays

Please see the Cost Management section in this booklet for details.

The Plan is a plan which contains an Exclusive Provider Organization.

EPO name: MedCost
Address: PO Box 25307
Winston-Salem, NC 27114-5307
Telephone: 800 824-7406
Website: www.medcost.com

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the EPO service area within a 30 mile radius of the Plan Participants zip code.

If a Covered Person is out of the EPO service area and has a Medical Emergency requiring immediate care. If services are incurred while traveling as long as the Plan Participant is not traveling for the purpose of seeking medical care. Dependents living outside of the EPO network will be paid as if within the EPO network.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.

If a Network Provider recommends the Covered Person go to a Non-Network Provider, this care will be covered as if that Provider were a Network Provider.

If a Network Provider orders Labs and X-rays from a non Network Provider, it will be covered as if in network.

If a Covered Person has a Medical Emergency and needs immediate medical care, this care will be covered at the rate shown in the Schedule of Benefits following.

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient.

Each Covered Person will be given, at no cost, a list of Network Providers, as well as additional explanations about this option and any rules that apply to designation of a primary care provider. This list will include providers who specialize in obstetrics or gynecology. Maximum reimbursement is received from the Plan when these medical care providers are used.

If a Non-Network Provider is seen without referral from a Network Provider, there will be no reimbursement from the Plan for medical services rendered or Hospitalization recommended by that Provider unless the treatment was for a Medical Emergency.

Dialysis Facilities will be considered a Non-Network provider unless a rate is contracted by the Plan.

Deductibles/Copayments payable by Plan Participants

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

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

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.

MEDICAL BENEFITS SCHEDULE

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$1,500	Not Applicable
Per Family Unit	$4,500	Not Applicable
The Calendar Year deductible is waived for the following Covered Charges: - Physician Office Visits and Wellness Care - Urgent Care Facility - Ambulatory Surgical Facility - Diabetic Supplies ordered through Edgepark Surgical, Inc, - Allergy Testing and Allergy serum and injections - Eye Exam		
COPAYMENTS		
Primary Physician visits (Primary Physicians include: Family Practice, Internal Medicine, Pediatricians, OB/GYN)	$35	Not Applicable
Specialist visits	$70	Not Applicable
Therapy Services and Vision Exams	$35 Primary / $70 Specialist	Not Applicable
Urgent Care Facility	$70	Not Applicable
Emergency Room Visit (medical emergency only)	$250	$250
Ambulatory Surgical Facility	$75	Not Applicable
The utilization review administrator, I ProCert must be notified at 888 319-6462 within 48 hours (72 hours on week-ends and holidays) of the admission, even if the patient is discharged within 48 hours (72 hours on week-ends and holidays) of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$3,500	Not Applicable
Per Family Unit	$10,500	Not Applicable
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 out-of-pocket maximum and are never paid at 100%. Cost containment penalties Spinal manipulation/chiropractic charges Amounts over Usual and Reasonable Charges		
COVERED CHARGES		
Hospital Services		
Room and Board	90% after deductible the semiprivate room rate	Not Applicable
Inpatient Room and Board Charges will not be covered if in excess of the number of days precertified.		
Intensive Care Unit	90% after deductible Hospital's ICU Charge	Not Applicable
Surgery/Anesthesia	90% after deductible	Not Applicable
Out Patient Facility	90% after deductible	Not Applicable

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Emergency Room Visit		
Medical Emergency	100% after copayment	100% after copayment
Medical Non-Emergency Care	Not Covered	Not Covered
Non Hospital Ambulatory Surgical	100% after $75 copayment	Not Applicable
Urgent Care Facility	100% after $70 copayment	Not Applicable
Skilled Nursing Facility	90% after deductible the facility's semiprivate room rate within 14 days of a 3 day stay	Not Applicable
Birthing Center	90% after deductible	Not Applicable
Diagnostic Testing (X-ray & Lab) without surgery	100%	Not Applicable
Physician Services		
Inpatient visits	90% after deductible	Not Applicable
Primary office visits	100% after $35 copayment	Not Applicable
Specialist office visits	100% after $70 copayment	Not Applicable
Office visits Include services and office diagnostics performed in and billed by the Physician's Office. Charges associated with the office visit may be billed by an independent facility.		
Second Surgical Opinion	100% after copayment	Not Applicable
Surgery	90% after deductible	Not Applicable
Allergy testing	100%	Not Applicable
Allergy serum and injections	100%	Not Applicable
Podiatry office visit	100% after $70 copayment	Not Applicable
Diagnostic Testing (X-ray & Lab) with surgery	90% after deductible	Not Applicable
Eye Exam	100% after $70 copayment $150 Calendar Year Maximum	Not Applicable
Home Health Care	90% after deductible	Not Applicable
Inpatient Prescription Drugs	90% after deductible	Not Applicable
Outpatient Private Duty Nursing	90% after deductible	Not Applicable
Hospice Care	90% after deductible	Not Applicable
Ambulance Service	90% after deductible	
Wig After Chemotherapy	90% after deductible	Not Applicable
Jaw Joint/TMJ office visit	100% after copayment	Not Applicable
Jaw Joint/TMJ related services	90% after deductible	Not Applicable
Oral Surgery	90% after deductible	Not Applicable
Occupational Therapy	100% after copayment	Not Applicable
Speech Therapy **(Expenses related to special education needs are not covered)**	100% after copayment	Not Applicable
Physical Therapy	100% after copayment	Not Applicable
Cardiac Rehabilitation	90% after deductible	Not Applicable
Kidney Dialysis **Includes training of (1) attendent for home dialysis (may be a family member)**	90% after deductible	Not Applicable
Chemotherapy and Radiation	90% after deductible	Not Applicable

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hearing Aids and Exams	100% after $70 copayment for exam and hearing aids up to a maximum of $3,000 in a 24 month period	100% after $70 copayment for exam and hearing aids up to a maximum of $3,000 in a 24 month period
Durable Medical Equipment	90% after deductible	Not Applicable
Prosthetics	90% after deductible	Not Applicable
Orthotics	90% after deductible	Not Applicable
Diabetic Supplies **Call Edgepark Surgical, Inc, (800 321-0591)**	90% (deductible waived)	Not Applicable
Sleep Disorders	90% after deductible	Not Applicable
Smoking Cessation	Patches are covered under the Prescription Drug Benefit	
Spinal Manipulation Chiropractic	100% after $70 copayment ($100 per visit) maximum 20 visits Calendar Year maximum	Not Applicable
Mental Disorders		
Inpatient	90% after deductible	Not Applicable
Outpatient	90% after deductible	Not Applicable
Physician Office Visit	100% after $35 copayment	Not Applicable
Substance Abuse		
Inpatient	90% after deductible	Not Applicable
Outpatient	90% after deductible	Not Applicable
Physician Office Visit	100% after $35 copayment	Not Applicable
Preventive Care		
Routine Well Adult Care (age 16 and above)	100%	Not Applicable
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, immunizations/flu shots, routine colonoscopies, bone density scans, stress tests, sigmoidoscopies and services required by applicable law if provided by a Network Provider. May be billed by Physician's office or an independent facility.		
Frequency limits for mammogram Ages 35 and over . . . . . annually		
Routine Well Newborn Inpatient Nursery Care	90% after deductible	Not Applicable
Routine Well Child Care Six (6) well baby visits under 12 months of age Two (2) well baby visits from 12 months up to 24 months	100%	Not Applicable
Routine Well Child Care (age 2 to age 16)	100%	Not Applicable
Includes: office visits, routine physical examination, laboratory tests, x-rays, immunizations and other preventive care and services required by applicable law if provided by a Network Provider.		
Organ Transplants	90% after deductible	Not Applicable
Pregnancy	90% after deductible	Not Applicable
Dependent daughters not covered.		

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT		
	NETWORK	**NON-NETWORK**
Pharmacy Option (30 Day Supply)		
Generic Drugs	$5 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Formulary Brand Name Drugs	$45 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Non-Formulary Brand Name Drugs	$60 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Speciality Drugs (Only available in a 30 day supply)	25% to a maximum of $100	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only
Pharmacy Option (60 Day Supply)		
Generic Drugs	$10 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Formulary Brand Name Drugs	$80 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Non-Formulary Brand Name Drugs	$120 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Pharmacy Option (90 Day Supply)		
Generic Drugs	$15 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Formulary Brand Name Drugs	$135 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Non-Formulary Brand Name Drugs	$180 copayment	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only.
Mail Order Option (90 Day Supply only)		
Generic Drugs	$10 copayment	Not Applicable
Formulary Brand Name Drugs	$90 copayment	Not Applicable
Non-Formulary Brand Name Drugs	$120 copayment	Not Applicable
Speciality Drugs (Only available in a 30 day supply)	25% to a maximum of $100	Non-Participating Pharmacy Coverage includes ingredient costs and dispensing fees only
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

Note: Retail multi-source brand drugs will be paid at 100% after a copayment equal to formulary or non formulary plus the cost difference between the brand drug dispensed and the generic equivalent not dispensed unless the multi-source brand drug is specified by the physician.

Note: Over the Counter Drugs are excluded from the Prescription Plan except for Over the Counter Prilosec and Claritin which are covered for a generic copayment.

Note: Voluntary Maintenance Choice: Members have the option of filling their maintenance prescriptions in 90 days supplies at a local CVS pharmacy or at mail order to benefit from a lower copayment.

You may choose to continue filling 30 day or 60 day supplies at retail without penalty

If you have any questions concerning your pharmacy benefits please contact RX Benefits at 800 334-8134.

DENTAL SCHEDULE OF BENEFITS

DENTAL BENEFITS

Calendar Year deductible, per person	$50

The deductible applies to these Classes of Service:

Class A Services - Preventive

Class B Services - Basic

Class C Services - Major

Dental Percentage Payable

Class A Services - Preventive	100% (after deductible)
Class B Services - Basic	80% (after deductible)
Class C Services - Major	50% (after deductible)
Class D Services - Orthodontia	60%

Note: No benefits are payable for Class C or Class D Services in the first 12 months of the Covered Person's coverage under the Plan.

Maximum Benefit Amount

For Class A, B, and C Services:
Per person per
Calendar Year $2,000

For Class D-Orthodontia:

Lifetime maximum per person..... $4,000