

Polk County Government Health and Welfare Benefit Plan

For Benefit Plan Year July 1, 2010 through June 30, 2011

**MAXIMUM LIFETIME
BENEFIT AMOUNT** \$1,000,000

Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total, which may be split between Network and Non-Network providers.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$500	\$1,000
Per Family Unit	\$1,500 (three persons)	\$3,000 (three persons)

The Calendar Year deductible is waived for the following Covered Charges:

- Preadmission testing
- PPO Wellness Benefit

COPAYMENTS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<u>Physician visits</u>		
Primary	\$25	N/A
Specialist	\$35	N/A
Hospital	N/A	\$250
Emergency Room	\$50	\$50

	NETWORK	NON-NETWORK
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	\$2,500	\$3,500
Per Family Unit	\$7,500 (three persons)	\$10,500 (three persons)

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%:

- Deductible(s)
- Outpatient substance abuse treatment charges
- Inpatient substance abuse treatment charges
- Cost containment penalties
- Copayments

COVERED SERVICES	NETWORK PROVIDERS	NON NETWORK PROVIDERS
<u>Hospital Services</u>		
Room and Board	80% after deductible the semiprivate room rate	50% after deductible and copayment, the semiprivate room rate
Intensive Care Unit	80% after deductible Hospital's ICU Charge	50% after deductible Hospital's ICU Charge
Emergency Room	80% after deductible and copayment	50% after deductible and copayment
Outpatient Facility	80% after deductible	50% after deductible
<u>Skilled Nursing Facility</u>		
	80% after deductible, the facility's semiprivate room rate within 14 days of a three day stay 70 days Calendar Year maximum	50% after deductible the facility's semiprivate room rate within 14 days of a three day stay 70 days Calendar Year maximum
<u>Physician Services</u>		
Inpatient visits	80% after deductible	50% after deductible
Office visits	100% after \$25 or \$35 copayment	50% after deductible
Surgery	80% after deductible	50% after deductible
<u>Home Health Care</u>		
	80% after deductible \$10,000 Lifetime maximum	50% after deductible \$10,000 Lifetime maximum
<u>Outpatient Private Duty Nursing</u>		
	80% after deductible 70 days Calendar Year maximum	80% after deductible 70 days Calendar Year maximum
<u>Hospice Care</u>		
Bereavement Counseling	80% after deductible 80% after deductible	50% after deductible 50% after deductible
<u>Ambulance Service</u>		
	80% after deductible	80% after deductible
<u>Jaw Joint/TMJ</u>		
	80% after deductible \$5,000 Lifetime maximum	50% after deductible \$5,000 Lifetime maximum
<u>Wig After Chemotherapy</u>		
	80% after deductible	50% after deductible
<u>Occupational Therapy</u>		
	80% after deductible	50% after deductible
<u>Speech Therapy</u>		
	80% after deductible	50% after deductible
<u>Physical Therapy</u>		
	80% after deductible	50% after deductible
<u>Durable Medical Equipment</u>		
	80% after deductible	50% after deductible

COVERED SERVICES	NETWORK PROVIDERS	NON NETWORK PROVIDERS
<u>Prosthetics</u>	80% after deductible	50% after deductible
<u>Orthotics</u>	80% after deductible	50% after deductible
<u>Spinal Manipulation Chiropractic</u>	50% after deductible	50% after deductible
<u>Mental Disorders</u>		
Inpatient	80% after deductible 10 days Calendar Year maximum	50% after deductible 10 days Calendar Year maximum
Outpatient	80% after \$35 copayment 20 visits Calendar Year maximum	50% after deductible 20 visits Calendar Year maximum
<u>Substance Abuse</u>		
Inpatient	80% after deductible	50% after deductible
Outpatient	50% after deductible	50% after deductible
Inpatient / Outpatient Combined	\$8,000 Calendar Year maximum \$16,000 Lifetime maximum	\$8,000 Calendar Year maximum \$16,000 Lifetime maximum
<u>Preventive Care</u>		
Routine Well Adult Care	100% \$400 Calendar Year maximum	50% after deductible \$400 Calendar Year maximum
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x rays, laboratory blood tests and immunizations/flu shots (Performed or billed by physician's office or independent facility)		
Frequency Limits for Mammogram Ages 40 and over annually		
Routine Colonoscopy 50 years of age and over – one every 5 years 80% deductible waived Not Covered Out of Network (Will be covered under 50 years of age if recommended by a Physician due to family history) The benefit will also cover any removal of polyps and laboratory charges associated with the Scheduled Routine Colonoscopy and will cover conscious sedation only. This benefit is not subject to the Annual Calendar Year Preventive Care maximum.		
Routine Well Newborn Care	80% after deductible	50% after deductible
Routine Well Child Care	100% \$300 Calendar Year maximum	50% after deductible \$300 Calendar Year maximum
Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations through age 18 or age 25 if a full time student (Performed or billed by physician's office or independent facility)		
<u>Organ Transplants</u>	80% after deductible	50% after deductible
<u>Pregnancy</u>	80% after deductible	50% after deductible
Employee and Dependent Spouse only, Dependent Daughters not covered		

PRESCRIPTION DRUG BENEFIT

Pharmacy Option

Generic drugs
Copayment \$10.00

Formulary Brand Name drugs
Copayment \$25.00

Non-Formulary Brand Name drugs
Copayment \$50.00

Mail Order Prescription Drug Option

Generic drugs
Copayment \$30.00

Formulary Brand Name drugs
Copayment \$75.00

Non-Formulary Brand Name drugs
Copayment \$150.00

**For Claims and Eligibility Questions, call:
Tucker Administrators, Inc.
800-347-1232**



This is a brief description of your coverage, and is not a contract. Should a discrepancy arise, the Plan Document and all of its provisions will prevail. The Plan Document sets forth in detail the rights and obligations of the insurer and insured.