
*Polk County Government
Health and Welfare Benefit Plan*

For Benefit Plan Year July 1, 2008 through June 30, 2009

**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

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
COPAYMENTS		
<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% \$300 Calendar Year maximum	50% after deductible \$300 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 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.