

CITY OF MARSHALLTOWN
BENEFIT SUMMARY
Administered by First Administrators, Inc.
Group #: 40057
Effective Date: January 1, 2011

All benefits are subject to the following deductibles, co-pays, coinsurance amounts and maximums unless otherwise stated.					
Claims must be filed within one year of the date the covered charges are incurred.					
MEDICAL BENEFITS	PATIENT'S LIABILITY			GENERAL PLAN LIMITS	PAGE
	PPO PLAN	NON PPO PLAN	OUT OF AREA PLAN		
Calendar Year Medical Deductible: - Individual Plan - Family Plan PPO Prosthetics (Limbs) Deductible: - Individual	\$500 \$1,000	\$1,000 \$2,000	\$500 \$1,000	Fourth quarter deductible carryover applies. <i>The PPO, Non-PPO and Out-of-Area deductibles are mutually satisfying.</i>	
	\$135	N/A	N/A	The PPO Prosthetics (Limbs) Deductible amount applies only to PPO services. The PPO Prosthetic (Limbs) Deductible accumulates to the Medical Deductible. Non-PPO and Out of Area prosthetic charges are subject to the medical deductible amount.	
Cost-sharing	10%	30%	20%	Cost-sharing amounts apply after the deductible has been met, unless otherwise specified.	
Calendar Year Out-of-Pocket Maximums: - Individual Plan - Family Plan	\$1,250 \$2,500	\$2,500 \$5,000	\$1,875 \$3,750	Includes Calendar Year Deductibles and 10%, 20% and 30% cost-sharing amounts. Excludes hospital preadmission certification penalty, case management penalty, mail order prescription drug program co-pays and PPO Office Services Co-pays. <i>The PPO, Non-PPO, and Out-of-Area out-of-pocket maximums are mutually satisfying.</i>	
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PPO Office Services Co-Pay**	\$20 co-pay	N/A	N/A	The \$20 co-pay does not apply to the calendar year deductible or the out-of-pocket maximum.	
<p>** PPO physician office services are paid at 100% subject to the PPO Office Services Copay for the first \$400 of eligible expenses, per visit. Eligible expenses from a PPO physician's office in excess of \$400 are subject to the PPO deductible and cost-sharing amounts up to the PPO out-of-pocket maximum. The PPO Offices Services Copay includes all services and/or treatment performed in the PPO physician's office except: allergy testing and injections; cardiac rehabilitation; chemotherapy; chiropractic benefits; dental services covered under the medical plan; occupational therapy; physical therapy; radiation therapy; respiratory/inhalation therapy; sleep studies, speech therapy; surgery; and CT scans, MRIs, and other nuclear imaging, which are considered at the deductible and cost-sharing levels specified in the Benefit Summary.</p> <p>Note: The PPO Office Services Copay will apply to office visits performed in an outpatient or ambulatory facility if the PPO physician does not have a local office.</p>					

Self-Audit Billing Credit	Participant earns 25% of the amount eliminated, to a maximum of \$500, for hospital and physician billing errors and/or discrepancies.	
<p>PPO NOTES:</p> <ol style="list-style-type: none"> 1. When a PPO provider refers a participant to a non-PPO provider, the covered expenses will be considered at the non-PPO benefit level. 2. Services and/or treatment received from Mayo Foundation providers will be considered at the PPO benefit level. 3. Services and/or treatment received from a VA (Veteran's Administration) hospital will be considered at the Out-of-Area benefit level. 4. When a covered participant resides outside the PPO area, or is traveling outside the PPO area for reasons other than medical care (e.g., business or vacation), and a non-PPO provider is used, eligible expenses from the non-PPO provider will be considered at the Out-of-Area benefit level. The PPO Office Services Copay provision will not apply to any office services received. 5. Services and/or treatment provided by a non-PPO provider, when there is no PPO provider available within the PPO area, will be considered at the Out-of-Area benefit level. 6. If a participant requires treatment for a medical emergency, and is unable to reach a PPO provider, eligible expenses from a non-PPO provider will be considered at the Out-of-Area benefit level until the patient is stabilized. After stabilization, the patient must be transferred to a PPO provider. If the patient is not transferred to a PPO provider upon stabilization, the eligible expenses from the non-PPO provider will be considered at the non-PPO benefit level from the point of stabilization. 7. Non-PPO emergency room physician charges will be considered at the PPO benefit level when services are provided in a PPO facility. 8. Ancillary services provided by a non-PPO provider in a PPO facility will be considered at the PPO benefit level. 9. Interpretation of x-ray and laboratory results ordered by a PPO provider, and provided by a non-PPO provider, will be considered at the PPO benefit level. 10. Charges for interpretation of x-ray or laboratory services performed in an independent radiology or pathology facility and billed by the PPO physician ordering the services will be considered in the same manner as any other x-ray or laboratory service performed in a PPO provider's office. <p><i>PPO Office Services Co-pays never apply to non-PPO physician office visits, even when a claim is paid at the PPO benefit level.</i></p> <p>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 <i>What Are Eligible Expenses?</i> section. The eligible expense is based on the PPO's fee schedule or discount, the maximum allowable fee, or the actual amount charged.</p>		
Utilization Review:	The Utilization Review program includes Preadmission Certification, Voluntary Prenatal Screening and Case Management.	
Preadmission Certification:	Failure to comply with the Hospital Preadmission Certification provision will result in a \$500 penalty applied to hospital-related inpatient charges. Precertification must take place prior to a planned admission or within 2 business days following an unplanned (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 will not apply to out-of-pocket maximums.	
Prenatal Screening Program:	If the participant complies with the voluntary Prenatal Screening Program and calls during the first trimester of the pregnancy, she will be eligible for a \$500 well baby care benefit.	
Case Management:	Failure to participate in Case Management will result in a \$500 penalty applied to all related charges.	

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MEDICAL BENEFIT SUMMARY (continued)

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MEDICAL BENEFITS	PLAN'S LIABILITY			GENERAL PLAN LIMITS	PAGE
	PPO PLAN	NON PPO PLAN	OUT OF AREA PLAN		
Allergy	90%	70%	80%	Includes testing and injections.	
Ambulance	90%	70%	80%	Limited to local air or ground.	
Ambulatory/Outpatient Surgery Facility	90%	70%	80%		
Anesthesia	90%	70%	80%	Includes CRNA benefits.	
Birth Center	90%	70%	80%		
Cancer Screening (Routine and Diagnostic) - Mammogram	100%	100%	100%	Deductible and PPO office services copay waived. To be used prior to Preventive Care Services. Limited as follows: Age 26 to 39: one baseline; Age 40 to 49: one every two years; Age 50 and older: one every year.	
- Pap Smears	100%	100%	100%	Limited to annual.	
- Prostate Screening	100%	100%	100%	Limited as follows: Age 40 to 49: one every two years; Age 50 and older: one every year.	
Cardiac Rehabilitation	90%	70%	80%	Limited to phase I (inpatient) and phase II (outpatient) treatment only; phase III treatment (diet, exercise, healthy lifestyle programs) is excluded. Services and/or treatment must be medically necessary and recommended or ordered by a physician.	
Chiropractic (Manual/Mechanical Manipulation of Spinal Column)	90%	70%	80%		
Colonoscopy	90%	70%	80%	Covered for the following diagnoses: Based on medical necessity; Family history; Routine: Age 50 and older, each 10 years;	
Sigmoidoscopy	90%	70%	80%	Covered for the following diagnoses: Based on medical necessity; Family history; Routine: each 5 years	
Contraceptive Management	90%	70%	80%	Includes injectable contraceptives (e.g., Depo-Provera), implantable contraceptives (e.g., Norplant), contraceptive devices (e.g., IUD) and surgical removal of contraceptives.	
Dental Services Covered Under Medical	90%	70%	80%	Includes surgical removal of impacted teeth. Excludes treatment of TMJ.	
Diabetic Self-Management Education Programs/Outpatient	90%	70%	80%		
Durable Medical Equipment	80%	80%*	80%	Rental not to exceed the purchase price. *PPO deductible and out-of-pocket maximum apply.	
Emergency Room Services	90%	70%	80%		
Hemodialysis (Kidney Disease Treatment)	90%	70%	80%		
Home Health Care	90%	70%	80%	Prior approval is required. Limited to 60 visits per calendar year.	

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MEDICAL BENEFIT SUMMARY (continued)

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MEDICAL BENEFITS	PLAN'S LIABILITY			GENERAL PLAN LIMITS	PAGE
	PPO PLAN	NON PPO PLAN	OUT OF AREA PLAN		
Hospice Care - Respite Care	90% 90%	70% 70%	80% 80%	Prior approval is required. Lifetime limit of 180 days. Limited to 14 days per calendar year.	
Hospital	90%	70%	80%	Limited to the semi-private room rate for the level of care the patient is receiving.	
Immunizations	100%	100%	100%	Deductible waived to age 7.	
Maternity Expense - Inpatient Newborn Care	90% 90%	70% 70%	80% 80%	Payable for all female participants. Considered separately from mother's charges. Includes nursery room and board, physician visits and circumcision.	
Mental Health/Chemical Dependency - Inpatient - Outpatient - Office	90% 90% **	70% 70% 70%	80% 80% 80%	Includes biologically based mental illness and residential treatment. **See PPO Office Services Co-pay for co-pay and cost-sharing percentages.	
Morbid Obesity	90%	70%	80%	Limited to surgical procedures only.	
Nursing Facility - Room and Board	90% 90%	70% 70%	80% 80%	Limited to 60 days per calendar year. Limited to the nursing facility's semi-private room rate for the level of care the patient is receiving.	
Outpatient Diagnostic X-ray and Laboratory	90%	70%	80%	See PPO Notes for exceptions.	
Physician Services - Inpatient - Outpatient Hospital - Office	 90% 90% **	 70% 70% 70%	 80% 80% 80%	Includes consultations; voluntary second or third surgical opinion; Physician's Assistant (if supervised by physician). Limited to one visit per day per specialty unless additional visits are medically necessary. ** See PPO Office Services Copay for copay and cost-sharing percentages.	
Preadmission Testing	90%	70%	80%		
Preventive Care	100%	100%	100%	Deductible and PPO Office Services Co-pay waived. Includes , but is not limited to, the following routine services: <ul style="list-style-type: none">• routine physical examinations• immunizations• mammograms*• pap smears*• diagnostic x-ray and labs• vision exams (including routine eyewear exams)• hearing exams• services for screening of "family history of" conditions** *Charges for mammograms and pap smears are in excess of the age scheduled Cancer Screening benefits. **Excludes surgical procedures, including colonoscopies and sigmoidoscopies.	
Private Duty Nursing	90%	70%	80%		
Prosthetics - Limbs - Other	90%* 90%	70% 70%	80% 80%	*Subject to Prosthetic (Limbs) Deductible. Medical deductible applies to all other prosthetic services.	
Radiation Therapy and Chemotherapy	90%	70%	80%		

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MEDICAL BENEFIT SUMMARY (continued)

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MEDICAL BENEFITS	PLAN'S LIABILITY			GENERAL PLAN LIMITS	PAGE
	PPO PLAN	NON PPO PLAN	OUT OF AREA PLAN		
Smoking Cessation Medications	100%	100%	100%	Deductible waived.	
Surgical - Inpatient - Outpatient - Assistant Surgeon	90% 90% 90%	70% 70% 70%	80% 80% 80%	Limited to 25% of the eligible expense for the surgical procedure performed.	
Therapy - Occupational Therapy - Physical Therapy - Respiratory/Inhalation Therapy - Speech Therapy	90% 90% 90% 90%	70% 70% 70% 70%	80% 80% 80% 80%	Excludes occupational therapy supplies.	
Transplant Benefits - Procurement	90% 90%	70% 70%	80% 80%	Prior approval is required. Includes heart, heart/lung, lung, liver, pancreas, kidney, kidney/pancreas, bone marrow, small bowel, stem cell and cornea.	
Well-Baby/Well-Child Care - With Prenatal Screening Compliance - Without Prenatal Screening Compliance	 100% 90%	 100% 70%	 100% 80%	Deductible and PPO Office Services Co-pay are waived. Limited to children up to age 7. Up to a limit of \$500 in services/lifetime; paid at applicable cost-sharing percentages thereafter. (90/70/80)	

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DENTAL BENEFIT SUMMARY (Cont.)

DENTAL BENEFITS	PATIENT'S LIABILITY		GENERAL PLAN LIMITS	PAGE
Dental Deductible: Per Individual/CAL YR Per Family/CAL YR	\$50 \$100		Waived for Preventive Benefits.	
	PLAN PAYS	PARTICIPANT PAYS		
Preventive Benefits	100%	0%	Deductible waived. Includes fluoride treatment (for dependent children only), oral exams, cleaning and x-rays.	
Basic Benefits	80%	20%	Includes fillings, root canals and periodontic treatment.	
Major Benefits	50%	50%	Includes crowns, bridges and dentures.	
Orthodontic Benefits	50%	50%		
	DENTAL PLAN'S MAXIMUM LIABILITY			
Calendar Year Maximum Benefit	\$1,500		Excludes Orthodontic Benefits and pediatric oral services (ages 0-18).	
Lifetime Orthodontic Benefit	\$1,500			
Dental Pretreatment Review: If treatment is expected to cost \$300 or more, a treatment plan and estimate should be submitted to the Benefit Services Administrator for preauthorization.				

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PRESCRIPTION BENEFIT SUMMARY (continued)

All benefits are subject to the following deductibles, co-pays, coinsurance amounts and maximums unless otherwise stated.

MEDICAL BENEFITS	PLAN'S LIABILITY	GENERAL PLAN LIMITS	PAGE
<p>Prescription Drugs</p> <p>Prescription Drug Discount Card - Retail Oral Cancer Drugs</p>	<p align="center">80%</p> <p align="center">80% 90%</p>	<p>PPO deductible and out-of-pocket maximum apply. Includes only those allowable drugs and medications that are not payable under the prescription drug card.</p> <p>Limited to 90-day supply per prescription or refill. Includes but is not limited:</p> <ul style="list-style-type: none"> • Legend Drugs • Compound drugs containing at least one legend drug • Dexedrine, Adderall, Desoxyn, and Ritalin for participants under age 23 • Oral contraceptives • Insulin, syringes, test strips, and insulin pens • Migraine drugs • Injectable drugs • Growth hormones (with prior approval) • Interferons • Prenatal Vitamins (prescription and over-the-counter) • Acne treatments • AIDS treatments • Chemotherapy • Syringes and needles <p>Excludes:</p> <ul style="list-style-type: none"> • Non-legend drugs • Biological sera, blood, or blood plasma (injectable) • Allergy extracts (injectable) • Anorexiant, except as noted above • Contraceptive injections, implants, and devices • Lancets, lancet devices, and glucose monitors • Fertility drugs • Fluoride products • Peridex • Cosmetic drugs • Rogaine/Minoxidil • Vitamins and minerals (excluding prenatal vitamins) • Anabolic steroids • Impotence drugs • Experimental/investigational drugs 	
<p>Mail Order Prescription Drug Program (MedTrak)</p> <p>Generic: \$30 co-pay Brand Name: \$60 co-pay</p>	<p align="center">100%</p>	<p>Limited to 90-day supply per prescription or refill.</p> <p>Copay per prescription or refill. Copay per prescription or refill.</p> <p>The co-pay does not apply to the calendar year deductible or out-of-pocket maximums. Mail order benefits are limited to maintenance medications.</p> <p>The pre-existing conditions exclusion period and coordination of benefits provisions in the benefit booklet do not apply to the mail order Prescription Drug benefits.</p>	

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