BENEFIT PLAN CHANGE FORM
AMENDMENT NO: 01-07

GROUP NAME: Wood County Employees Plan

GROUP NUMBER: EWOOD

TYPE OF CHANGE: MEDICAL x **DENTAL** **OTHER**

PLAN AMENDMENT
The Plan Document is hereby amended as follows:

SECTION III: **Health Care Benefits, Schedule of Benefits, Comprehensive Medical Expense Benefits**

1) Co-Pays, Benefit Percentages and Co-Insurance Amounts

2) Covered Benefits, Physical Examinations

3) Covered Benefits, Medical Supplies, Equipment and Appliances, Prosthetic Appliances

4) What is Not Covered, #43

DELETE:

Co-pays, Benefit Percentages and Co-insurance Amounts			
Covered Charges	**Network Providers**	**Non-Network Providers**	**Benefit Limits (Network and Non-Network combined)**
Ambulance	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	
Durable Medical Equipment	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Hearing Aids are limited to a maximum payment of $1,500 per Covered Person every 24 months.
Extended Care Facility/Skilled Nursing Facility	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Daily room & board limited to the facility's Semi-Private room rate **Pre-Certification Required**

Home Health Care/ Hospice	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Home Health Care services are limited to 120 visits per Calendar Year
Hospital Services: *Inpatient (except treatment of Mental or Nervous Conditions and Substance Abuse)*	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Daily room & board charges limited to the Hospital's Semi-Private room rate **Pre-Certification Required**
Hospital Services: *Emergency room for Injury or Medical Emergency*	You pay a $35 technical service fee per visit, then after the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	You pay a $35 technical service fee per visit, then after the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	**Treatment must be rendered within 72 hours of onset of symptoms** For a definition of Medical Emergency, refer to the Definitions section of this Booklet (*Section IX*)
Hospital Services: Emergency Room for Illness that does not qualify as a Medical Emergency	Not covered.	Not covered.	
Hospital Services: *Outpatient Services (except treatment of Mental or Nervous Conditions and Substance Abuse)*	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	
Hospital Services: Pre-Admission Testing	The Plan pays 100% of Covered Charges.		Not subject to Deductible or Co-insurance

Mental or Nervous treatment – Inpatient	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to 45 days Confinement per Calendar Year (combined with Substance Abuse Inpatient treatment) Covered Services for Substance Abuse are paid according to the following after Deductible and Co-Insurance are applied: 1st admission is 100% of Covered Services 2nd admission is 80% of Covered Services 3rd admission is 50% of Covered Services 4th admission and all subsequent admissions is 0% of Covered Services **Pre-Certification is Required**
Substance Abuse treatment – Inpatient	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to 45 days Confinement per Calendar Year (combined with Mental or Nervous Inpatient treatment) **Pre-Certification Required**
Mental or Nervous and Substance Abuse Treatment – Outpatient	You pay a $10 professional service fee per visit, then after the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	You pay a $10 professional service fee per visit, then after the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	**Pre-Certification required after the tenth (10) visit per condition or course of treatment**
Physician Services*:* Musculoskeletal Manipulations, Adjustments and Related Modalities (chiropractic care/ spinal manipulations)	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to 12 visits per Calendar Year <u>Note</u>: Professional service fee will apply if office visit charge is made
Physician Services: Second Surgical Opinions	The Plan pays 100% of Covered Charges.		Not subject to Deductible or Co-insurance

Physician Services: Inpatient and Outpatient, including Office Surgical Procedures	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Note: Professional service fee will apply if office visit charge is made
Private-Duty Nursing	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to $5,000 maximum per calendar year
Routine Preventive Care (Outpatient): Well-Infant Care up to age 1 year	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible and is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to $500 maximum Benefit per Calendar Year Note: Professional service fee will apply if office visit charge is made
Routine Preventive Care (Outpatient): Well-Child Care for ages 1 year through 16 years	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to $500 maximum Benefit per Calendar Year Note: Professional service fee will apply if office visit charge is made
Routine Preventive Care (Outpatient): Physician Charges for Pap Test, Mammogram and Gynecological & Prostate Exam	You pay a $10 professional service fee per visit, then after the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	You pay a $10 professional service fee per visit, then after the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to 1 per Calendar Year
Routine Preventive Care (Outpatient): Lab Charges for Routine Pap test, Mammogram and PSA	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to 1 per Calendar Year
Routine Preventive Care (Outpatient): Routine Physical Exam from age 16 and above Includes Diagnostic Services	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to a maximum Benefit of $500 per Calendar Year Note: Professional service fee will apply if office visit charge is made Immunizations are Not Covered

Vision Therapy	After the Deductible is met, the Plan pays 50% of Covered Charges. You pay the other 50%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 50% of Covered Charges. You pay the other 50%, subject to the Co-insurance limit.	Diagnosis of Strabismus is required for vision therapy services to be covered Limited to 1 course of treatment per Lifetime, maximum of 32 visits <u>Note</u>: Professional service fee will apply if office visit charge is made No coverage for home therapy
All Other Therapy services	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Occupational and Physical Therapy Services are limited to 30 visits per Calendar Year **Occupational and Physical Therapy services combined require Pre-Certification for any visits in excess of 15 per Calendar Year** <u>Note</u>: Professional service fee will apply if office visit charge is made
All Other Covered Charges - Diagnostic Services (non-Hospital) - Medical Supplies - Oxygen - Prosthetics - Diabetic Nutritional Counseling*****	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	*****Diabetic Nutritional Counseling: - Coverage limited to Covered Persons diagnosed with Diabetes only - Limited to 2 sessions per Calendar Year - Professional service fee will apply if office visit charge is made

REPLACE WITH:

Co-pays, Benefit Percentages and Co-insurance Amounts

Covered Charges	Network Providers	Non-Network Providers	Benefit Limits (Network and Non-Network combined)
Ambulance	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	
Durable Medical Equipment	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Hearing Aids are limited to a maximum payment of $3,000 per Covered Person every 4 years, beginning January 1, 2007.
Extended Care Facility/Skilled Nursing Facility	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Daily room & board limited to the facility's Semi-Private room rate **Pre-Certification Required**
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Hospital Services: *Inpatient (except treatment of Mental or Nervous Conditions and Substance Abuse)*	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Daily room & board charges limited to the Hospital's Semi-Private room rate **Pre-Certification Required**
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Routine Preventive Care (Outpatient): Routine Physical Exam from age 16 and above Includes Diagnostic Services and Immunizations	After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit.	After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit.	Limited to a maximum Benefit of $500 per Calendar Year Note: Professional service fee will apply if office visit charge is made

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DELETE: 43. For immunizations for Covered Persons 16 years of age and older.

DELETE: **<u>Physical Examinations</u>**

Regardless of Medical Necessity, benefits are payable for all Covered Persons over age sixteen for medically appropriate routine or periodic exams and physicals including medically appropriate Diagnostic Services. Benefits are provided up to a Payment Maximum of $500 per Calendar Year.

Some physicals, such as those required by a child's school, are covered. Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, are not covered.

Immunizations are not covered.

All Covered Services are subject to the Deductible and Co-insurance specified in the Schedule of Benefits.

REPLACE WITH:

Physical Examinations

Regardless of Medical Necessity, benefits are payable for all Covered Persons over age sixteen for medically appropriate routine or periodic exams and physicals including medically appropriate Diagnostic Services. Benefits are provided up to a Payment Maximum of $500 per Calendar Year.

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Immunizations are covered.

All Covered Services are subject to the Deductible and Co-insurance specified in the Schedule of Benefits.

DELETE:

Prosthetic appliances - purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body organ and its adjoining tissues.
- Replace all or part of the function of a permanently useless or malfunctioning body organ.

Benefits for prosthetic appliances include the first lens(es) following cataract Surgery and the first breast prostheses and surgical brassiere following a mastectomy.

Benefits are provided for hearing aids (includes initial office and follow-up visits related to an examination for prescribing or fitting of hearing aid) up to a maximum payment of $1,500 per Covered Person in a 24 month period, subject to any applicable Deductible or Co-insurance.

REPLACE WITH:

Prosthetic appliances - purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body organ and its adjoining tissues.
- Replace all or part of the function of a permanently useless or malfunctioning body organ.

Benefits for prosthetic appliances include the first lens(es) following cataract Surgery and the first breast prostheses and surgical brassiere following a mastectomy.

Benefits are provided for hearing aids (includes initial office and follow-up visits related to an examination for prescribing or fitting of hearing aid) up to a maximum payment of $3,000 per Covered Person every 4 year period beginning January 1, 2007, subject to any applicable Deductible or Co-insurance.

ADD SECTION:

EFFECTIVE DATE: January 1, 2007

RECEIVED
BY:

Client **Date**