City of Chester
SCHEDULE OF BENEFITS
Effective 07/01/11

This is a **summary** of the benefits under your Group Medical and Vision Plan. The **Summary Plan Document** has complete details on benefits and exclusions and can be accessed via the web at mbstpa.com . Benefits are only payable under the Plan for eligible expenses. The Preferred Provider Network (PPO), MedCost Preferred is the network with which the City of Chester has contracted. Services received from NON-PPO providers will be subject to Usual, Customary and Reasonable (UCR) allowances.

MEDICAL		
	PPO Providers	**Non-PPO Providers**
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Maximum	$2 million per Calendar Year	$2 million per Calendar Year
Calendar Year Deductible		
Individual	$1,000	$1,000
Family Maximum	3 per family	3 per family
Calendar Year Out-of-Pocket Maximum		
Individual	$3,500 plus deductible	$4,500 plus deductible
Family Maximum	$7,000 plus deductible(s)	$9,000 plus deductible(s)
Note: The Calendar Year Out-of-Pocket Maximum does not include the following: **Deductible** **Co-Payments** **Pre-Certification Penalties** **Private Duty Nursing** **Prescription Drug Card Co-Payments & Co-Insurance**		
COVERED SERVICES		
Alcohol & Substance Abuse Services		
Inpatient Hospital Facility **See Pre-Certification Requirement**	70% after deductible	50% after deductible
Partial Hospitalization	70% after deductible	50% after deductible
Outpatient Hospital Facility	70% after deductible	50% after deductible
Physician Office Visit Care	100% after $20 copay	50% after deductible
Allergy Injections/Serum Services	70% after deductible	50% after deductible
Ambulance Services	70% after deductible	70% after deductible
Anesthesia Services	70% after deductible	50% after deductible
Chemotherapy/Radiation Therapy/ Infusion Therapy	70% after deductible	50% after deductible
Durable Medical Equipment	70% after deductible	50% after deductible
Emergency Room Facility Services	70% after co-payment and deductible	50% after co-payment and deductible
Co-Payment per Visit (Waived if Admitted)	$100	$100
Emergency Room Physician Services Includes lab & x-ray services performed in the Emergency Room	70% after deductible	50% after deductible

MEDICAL		
	PPO Providers	**Non-PPO Providers**
Extended Care/Skilled Nursing Facility Limited to 60 days per Calendar Year	70% after deductible	50% after deductible
Home Health Care Limited to 100 visits per Calendar Year for NON-PPO providers	70% after deductible	50% after deductible
Hospice Care	70% after deductible	50% after deductible
Hospital Services-Facility		
Inpatient **See Pre-Certification Requirement**	70% after deductible	50% after deductible
Outpatient	70% after deductible	50% after deductible
Laboratory and X-ray Services		
Inpatient	70% after deductible	50% after deductible
Outpatient	70% after deductible	50% after deductible
Independent Lab Facility	70% after deductible	50% after deductible
In Physician's Office	100% after office visit co-payment	50% after deductible
Manipulative Treatment Limited to $50 per visit and 24 visits per Calendar Year	70% after deductible	50% after deductible
Maternity Care Services		
Physician Charges Office Visit Co-payment for **initial visit only**	100% after co-payment $35	50% after deductible
Pre-Natal Care	70% after deductible	50% after deductible
Labor & Delivery Care	70% after deductible	50% after deductible
Hospital Charges	70% after deductible	50% after deductible
Medical Supplies	70% after deductible	50% after deductible
Mental/Nervous Disorder Services		
Inpatient Care **See Pre-Certification Requirement**	70% after deductible	50% after deductible
Partial Hospitalization	70% after deductible	50% after deductible
Inpatient Physician Care	70% after deductible	50% after deductible
Physician Office Visit Care	100% after $20 copay	50% after deductible
Newborn Nursery Care See Hospital and Physician Services for newborn expenses exceeding mother's length of stay.	70% deductible waived	50% deductible waived

MEDICAL		
	PPO Providers	**Non-PPO Providers**
Physical/Occupational Therapy Limited to 40 visits per condition	70% after deductible	50% after deductible
Physician Services		
Primary Care Physician Office Visit	100% after co-payment	50% after deductible
Co-payment per Office Visit Includes lab and x-ray services performed and billed by the physician's office	$20	
Primary Care Physician is defined as: Family Practice, General Practice, Internal Medicine, Pediatricians and OB/GYN		
Specialty Care Physician Office Visit	100% after co-payment	50% after deductible
Co-payment per Office Visit Includes lab and x-ray services performed and billed by the physician's office	$50	
Surgery performed in Physician's office	70% after deductible	50% after deductible
Inpatient Physician Services	70% after deductible	50% after deductible
Outpatient Physician Services	70% after deductible	50% after deductible
Pre-Admission Testing	70% after deductible	50% after deductible
Private Duty Nursing	70% after deductible	50% after deductible
Routine Foot Care Limited to $300 per Calendar Year	70% after deductible	50% after deductible
Second Surgical Opinion	100% after office visit co-payment	50% after deductible
Speech Therapy	70% after deductible	50% after deductible
Surgical Sterilization	70% after deductible	50% after deductible
TMJ Services Limited to a $3,000 Lifetime Maximum	70% after deductible	50% after deductible
Urgent Care Facility		
Primary Care Physician Office Visit	100% after co-payment	50% after deductible
Co-payment per Office Visit	$20	
Specialist Physician Office Visit	100% after co-payment	50% after deductible
Co-payment per Office Visit	$50	
Includes lab and x-ray services performed and billed by the physician's office		

MEDICAL		
	PPO Providers	**Non-PPO Providers**
Wellness Care Services		
Routine Adult Wellness Services - Coverage includes routine physical exam, routine lab & x-ray services, routine GYN exams, routine pap smears, routine prostate exam and related lab tests (i.e., PSA), and immunizations.	100% deductible waived	100% deductible waived
Routine/Diagnostic Mammograms	100% deductible waived	100% deductible waived
Routine/Diagnostic Colonoscopies	100% deductible waived	100% deductible waived
Routine Well Child Services – to age 19 Coverage includes routine physical exam, routine lab & x-ray services, routine hearing and vision tests and routine immunizations.	100% deductible waived	100% deductible waived
All Other Covered Expenses	70% after deductible	50% after deductible

ORGAN/TISSUE TRANSPLANT BENEFITS		
Covered Services	**Approved Transplant Facility**	**Non-Approved Facility**
MedCost Benefit Services must be notified **PRIOR** to a transplant evaluation. Precertification and Case Management is **required** for all transplant services. **Benefits will be reduced 50% for non-compliance.**	100%, deductible waived	Not Covered
Travel and Lodging For the patient and a caregiver	100%, up to $10,000 per Lifetime	Not Covered

INPATIENT PRE-CERTIFICATION REQUIREMENT

Pre-Certification is required for all inpatient hospital admissions. In case of an emergency admission, please call the Utilization Review Firm shown on your ID card within 48 hours or the next working day. **If pre-certification is not obtained prior to an elective confinement, the covered person will be responsible for the total billed charges. NOTE: Certification does not guarantee coverage. Certain procedures may not be eligible covered health services. Please contact the MedCost Benefit Services at the number shown on your ID card to inquire if the service is subject to any Plan limitations or exclusions.**

OUTPATIENT REVIEW

Outpatient Review concentrates on services that are costly or highly utilized. Precertification is **<u>required</u>** for the following diagnostic procedures:

- **CT scan** performed as an Outpatient or in a Physician's office
- **MRI** performed as an Outpatient or in a Physician's office
- **PET** scan performed as an Outpatient or in a Physician's office

Precertification for these services should be requested **at least 48 hours** before the service is provided. You should call MedCost Benefit Services at 800-795-1023 with the following information:

- The name of the patient and relationship to the covered Employee
- The name, patient identification number and address of the covered Employee
- The name and group number of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility and proposed date of the procedure
- The diagnosis and/or type of service to be provided

Please remember that precertification does not guarantee coverage or payment. Contact Customer Services at 800-795-1023 to verify your eligibility and benefits.

NOTE: The Physician Office Co-payment applies to PPO Physician's services that are performed in the PPO Physician's office with the **exception of the following**:

Allergy Injections and Serum expenses
Manipulative Treatment
Prenatal Office Visits (after the initial visit)
Chemotherapy/Radiation Therapy/Infusion Services
Physical/Occupational/Speech Therapy
Surgery and related expenses

All of the charges are subject to the Calendar Year deductible and will be payable at the applicable percentage outlined above.

PRESCRIPTION DRUG BENEFITS	
This Plan offers a formulary program called "Reference Formulary" in order to encourage the use of generics. This program will ultimately benefit Plan Participants by saving them money. This program encourages Plan Participants to try appropriate generic drugs in place of certain brands and assists pharmacies and physicians in this regard. Formulary name brand drugs are covered; however, **for all prescribed Non-Preferred Name Brand drugs, the Plan will require the Plan Participant to try a generic equivalent first.** Please contact the prescription drug card administrator at the number on your ID card with any questions you may have about this program.	
Retail Pharmacy Prescription Drug Benefit **Limited to 30 day supply per co-payment**	**Generic - $10 co-payment** **Formulary Name Brand – $30 co-payment** **Non-Preferred Name Brand – $50 copayment** **Specialty Drugs - $75 co-payment**
Mail Order Prescription Drug Benefit **Limited to a 90 day supply per co-payment**	**Generic - $25 co-payment** **Formulary Name Brand-$75 copayment** **Non-Preferred Name Brand – $125 copayment**

DENTAL BENEFITS	
COVERED SERVICES	**Percentage and/or Dollar Amount**
Calendar Year Deductible Individual Family Maximum	 $50 3 per family
Calendar Year Maximum Benefit (Types B & C only)	$1,000-Does not apply to dependents under age 19
Lifetime Orthodontic Benefit	$1,000
Type A – Preventative Services	100% deductible waived
Type B – Restorative Services	80% after deductible
Type C – Major Services	50% after deductible
Type D – Orthodontia Services	50% deductible waived