

**AMENDMENT #1**

**To Plan Document Dated January 1, 2009  
and Restated January 1, 2018**

**PERRY COUNTY  
EMPLOYEE MEDICAL PLAN  
PPO PLAN**

The following changes to the Plan Document are effective February 1, 2019:

1. Schedule of Benefits, pages 21 and 24, are deleted in their entirety and replaced with the attached revised pages 21 and 24.

2. Major Medical Expense Benefits, Hearing Screening, page 41, is deleted and replaced as follows:

**Hearing Screening.** The charges for hearing screening as required for Preventive Care for Children.

3. Major Medical Expense Benefits, Vision Screening, page 45, is deleted and replaced as follows:

**Vision Screening.** The charges for routine vision screening as required for Preventive Care for Children.

4. Major Medical Plan Exclusions and Limitations, Hearing Exams and Hearing Aids/Devices, page 47, is deleted and replaced as follows:

**Hearing Exams and Hearing Aids/Devices.** Charges incurred in connection with routine hearing exams and charges for the purchase or fitting of hearing aids/devices or such similar aid devices. This exclusion does not apply to routine hearing screenings as required for Preventive Care for Children or the initial purchase of a hearing aid if the loss of hearing is a result of an Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.

5. Major Medical Plan Exclusions and Limitations, Vision Exam and Eyewear, page 50, is deleted and replaced as follows:

**Vision Exam and Eyewear.** Charges incurred in connection with routine vision exams or eye refractions, and the purchase or fitting of eyeglasses and contact lenses. This exclusion/limitation shall not apply to routine vision screenings as required for Preventive Care for Children or the initial purchase of eyeglasses or contact lenses following cataract Surgery.

In all other respects, the Plan Document remains unchanged.

Acknowledged by:

Perry County:

By: Pamela Goffinet  
Printed Name: Pamela Goffinet  
Title: Auditor  
Date: 6-12-19

GPA:

By: Kathy Enochs  
Printed Name: KATHY ENOCHS  
Title: CEO  
Date: 6/14/19

## SCHEDULE OF BENEFITS (Cont'd)

	<u>PPO Benefit</u>	<u>Non-PPO Benefit</u>
<b>Teladoc Telephone Consultation</b> (Effective 3/1/18)	100%, Deductible waived	
<b>All Other Physician Services</b>	80% after Deductible	50% after Deductible
<b>Maternity</b> (Including prenatal care, delivery and postnatal care) Lab and X-ray Benefit applies. Contact Utilization Review for Coordination of Care.	80% after Deductible	50% after Deductible
<b>Routine Newborn Care</b> (Including Inpatient Hospital nursery charges and pediatric care to date of mother's discharge) Separate Deductible applies to newborn.	80% after Deductible	50% after Deductible
<b>Chemotherapy/Radiation Therapy/ Infusion Therapy</b> Contact Utilization Review for Coordination of Care.	80% after Deductible	50% after Deductible
<b>Dialysis</b>	80% after Deductible	50% after Deductible
<b>Cardiac Rehabilitation</b>	80% after Deductible	50% after Deductible
<b>Physical Therapy</b>	80% after Deductible	50% after Deductible
Maximum Number of Covered Visits Per Calendar Year	25	
<b>Occupational Therapy</b>	80% after Deductible	50% after Deductible
Maximum Number of Covered Visits Per Calendar Year	25	
<b>Speech Therapy</b>	80% after Deductible	50% after Deductible
Maximum Number of Covered Visits Per Calendar Year	25	
<b>Durable Medical Equipment (DME)/ Orthotic Devices/Prosthetics</b> UR Notification required for DME and Prosthetics or penalty applies	80% after Deductible	50% after Deductible
<b>Orthotic Insoles</b> (Diabetic patients only)	80% after Deductible	50% after Deductible

## SCHEDULE OF BENEFITS (Cont'd)

	<u>PPO Benefit</u>	<u>Non-PPO Benefit</u>
<p><b>Preventive and Wellness Care Benefits</b>            This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed illness or injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.</p>	<p>100%; Deductible waived</p>	<p>50% after Deductible</p>

**Examples of Covered Wellness Procedures to include but are not limited to:**

1. Routine Physical Exam
2. Annual Well Woman Exam
3. Annual Pap smear and other routine lab
4. Annual Mammogram (routine)
5. Bone Density test (routine)
6. Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. Routine lab\*, x-ray, diagnostic testing and other medical screenings
11. Routine Vision Screening for Covered Dependent Children
12. Routine Hearing Screening for Covered Dependent Children
13. Routine Colonoscopy (including polyp removal - beginning at age 50 with or without a diagnosis or Family history of colon cancer)
14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Calendar Year with four tobacco cessation counseling sessions per attempt)
15. All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures

**NOTE:** Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

\* Note: Labs billed by Perry County Memorial Hospital are covered at 100%, Deductible waived.

<p><b>All other Covered Medical Expenses not listed in the Schedule of Benefits are payable at the applicable Benefit Percentage after satisfying the Calendar Year Deductible subject to Plan Maximums and Limitations.</b></p>	<p>80% after Deductible</p>	<p>50% after Deductible</p>
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