DODGE COUNTY HOSPITAL

Effective October 1, 2011
SCHEDULE OF BENEFITS

The personal coverage benefits and the dependent coverage benefits for which an employee is covered under this plan shall be those shown in the following Schedule:

MAJOR MEDICAL EXPENSE BENEFITS	**PPO (In-Network)**	**NON-PPO (Out-of-Network)**
Penalty for Non-Compliance with Pre-Certification Requirements	$500	$500
Hospital Emergency Room Co-pay per Visit	$150 co-pay	$150 co-pay
Hospital 'Per admission' Deductible	None	$200
Cash Deductible (all-inclusive) (applies to all covered expenses unless otherwise specified)	$1000	$1000
Family Deductible (cumulative)	X3	X3
Doctor's Office Visit charge (includes allergy injections billed alone)	$35 co-pay, then 80%	Deductible, then coinsurance
X-Ray/Lab Tests Performed in Doctor's Office	80%, Deductible waived	Deductible/60%
X-Ray/Lab Tests at Hospital or Free-standing	Deductible/80%	Deductible/60%
Chemical Dependency Facility		
Hospital-based Physicians charges (Anesthesiologists, Radiologists & Pathologists)	Deductible/80%	Deductible/60%
Co-Insurance Percentage	80%	60%
Maximum Out-of-Pocket (Not including Deductible)		
Individual	$5,000	$10,000
Family	X3	X3

Note: PPO and Non-PPO Out of Pocket amounts are NOT integrated

Benefit Period	Calendar Year
Maximum Annual Benefit per Covered Person	$750,000
Maximum Lifetime Benefit per Covered Person	Unlimited

In-Patient Room & Board Rate Limits:	
Semi-Private Room	Usual and Customary Charge
Private Room[1]	Most common semi-private
ICU or CCU	Usual and Customary Charge
Miscellaneous Services	Usual and Customary Charge

The Doctor's Office Visit co-payment and benefit penalties do not apply to the deductible or out-of-pocket limit, and continue after the deductible and out-of-pocket limits are met.

[1] In the event a hospital does not contain semi-private rooms, the private room limit is 90% of the hospitals lowest priced private room. If a private room or isolation room is medically necessary due to contagious disease, the hospital's Usual and Customary Charge for such room will be a covered expense.

SCHEDULE OF BENEFITS (cont'd)

MATERNITY EXPENSES [2]	SAME AS ANY OTHER ILLNESS
Routine Nursery Care	Included as an expense of the baby
SKILLED NURSING FACILITY	Maximum $3,480 per calendar year
HOSPICE CARE	Maximum $10,000 per calendar year
HOME HEALTH CARE	Maximum $2,500 per calendar year
SUPPLEMENTAL ACCIDENT BENEFIT	1st $500 per accident payable at 100%, with regular benefits thereafter

	PPO (In-Network)	**NON-PPO (Out-of-Network)**
CHIROPRACTIC CARE		
Benefit	$25 co-pay	Deductible/coinsurance
Maximum Benefit payable per Year	$1,200	
MENTAL OR NERVOUS DISORDER; SUBSTANCE ABUSE	No Coverage	No Coverage
WELLNESS BENEFIT – Adult & Child (Eye Exams are included up to $100)	Covered at 100%	N/A
PRE-ADMISSION TESTING	100%	Deductible, then 100%
AIR AMBULANCE	Deductible/60%	Deductible/60%

PRESCRIPTION DRUGS

Tier I – Generic	$10/30% cost of drug after $150
Tier II – Specified Brand / Non-Generic	$30/30% cost of drug after $150
Tier III – Brand (Non-Preferred) and Compound Drugs	30% cost of drug under $150 50% cost of drug over $150

WAITING PERIOD	90 Days
ELIGIBILITY DATE	1ST of the month following or coincident with the waiting period

NOTE—MANDATORY PRE-ADMISSION CERTIFICATION PROGRAM – NON-EMERGENCY, ELECTIVE HOSPITALIZATION OR OUT-PATIENT SURGERY MUST BE CERTIFIED BEFORE A COVERED PERSON ENTERS THE HOSPITAL. Refer to page 2 of the Plan Document for details.

[2] No maternity coverage for dependent children.