

SUMMARY OF MATERIAL MODIFICATIONS NO. 9

This modification is made as of the 1st day of July, 2009, by the Southeast Polk Community School District to the Southeast Polk Community School District Health Benefit Plan (SelectFirst™). All other terms and provisions of the Plan remain unaltered and in effect.

The following **replaces** the heading on the current Benefit Summary.

**SE POLK COMMUNITY SCHOOL DISTRICT
BENEFIT SUMMARY (SELECTFIRST™ 2000)**

Effective: July 1, 2009

The following Benefit Summary (SelectFirst™ 2009) is **added** to the current benefit book.

**SE POLK COMMUNITY SCHOOL DISTRICT
BENEFIT SUMMARY (SELECTFIRST™ 2009)**

Effective: July 1, 2009

PHYSICIAN SERVICES			PAGE
<p>PPO Physicians – If services are performed by a SelectFirst™ physician, you will be responsible for either a co-pay or a percentage of the fee schedule allowance and any applicable calendar year deductible. This plan will pay the balance up to the fee schedule allowance. You will not be responsible for any unpaid charges in excess of the fee schedule allowance.</p> <p>Non-PPO Physicians within the SelectFirst™ area – If services are performed by a non-SelectFirst™ physician, within the SelectFirst™ area, you will be responsible for a co-pay and/or a percentage of the fee schedule allowance and any applicable calendar year deductible. This plan will pay the balance up to the fee schedule allowance. You will also be responsible for any unpaid charges in excess of the fee schedule allowance.</p> <p>Non-PPO Physicians outside the SelectFirst™ area – If services are provided by a non-SelectFirst™ physician, outside the SelectFirst™ area, you will be responsible for a co-pay and/or a percentage of maximum allowable fee, and any applicable calendar year deductible. This plan will pay the balance up to the maximum allowable fee. You will also be responsible for any unpaid charges in excess of the maximum allowable fee.</p> <p>Physician office services include all services and/or treatment performed in the physician's office with the exception of allergy injections and x-ray and laboratory services. For additional information, please refer to the allergy and the outpatient diagnostic x-ray and laboratory benefit sections below.</p>			
MEDICAL BENEFITS	YOU PAY		GENERAL PLAN LIMITS
	PPO PAYS	NON-PPO PAYS	PAGE
Physician's Office Co-Pay – Primary Care Physician	\$10 per visit	80%	The calendar year deductible is waived for services subject to a co-pay. Does not apply to the calendar year deductible or the out of pocket maximum.
Physician's Office Co-Pay – Specialist	\$20 per visit	80%	
Routine Vision Exam Co-pay	\$10 per visit	80%	
<p>NOTE: Specialists are defined as all physicians except for Ob/Gyn, Pediatrics, Family Practice, General Medicine, Physician's Assistants, Geriatrics, Osteopaths, and Chiropractors.</p>			
MEDICAL BENEFITS	YOU PAY		GENERAL PLAN LIMITS
	PPO PAYS	NON-PPO PAYS	PAGE
Emergency Room Co-Pay	\$75 Co-Pay then 100%	90%	PPO Deductible waived. Emergency room co-pay will be waived if admitted.
Medical Deductible to be paid before the following benefits are paid: - Per Individual/CAL YR - Per Family/CAL YR	\$300 \$600	\$600 \$1,200	4 th Quarter carryover applies. Common accident waiver applies.
Out-of-Pocket Maximum Amount: - Per Individual/CAL YR - Per Family/CAL YR	\$800 \$1,600	\$1,600 \$3,200	Includes coinsurance and calendar year deductible. Excludes co-pays, coinsurance amounts for the treatment of infertility and any

			penalties for noncompliance with the preadmission certification provision.	
<p>Utilization Review: The Utilization Review program includes Preadmission Certification</p> <p>Penalty for: Hospital Preadmission Certification for all SelectFirst™ stays - the facility is responsible for obtaining pre-certification.</p> <p>Non-Compliance: Hospital Preadmission Certification for all other stays - the employee is responsible for obtaining pre-certification. Preadmission Certification must occur prior to planned admissions or within 48 hours of admission for emergency admissions. If you fail to comply with this provision, the charge submitted will be reduced by 25% up to a \$500 maximum, before benefits are calculated. This penalty will not apply toward the out-of-pocket maximum.</p>				
MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Allergy Services	100%	80%	Co-pay and deductible waived for allergy injections. Subject to \$10 co-pay.	
Ambulance Benefits	90%	80%	Includes air or ground ambulance to the nearest adequate hospital or nursing facility.	
Ambulatory/Outpatient Surgery (facility charge)	90%	80%		
Anesthesia	90% 50%	80% 50%	Includes services provided by a CRNA. Services provided by the surgeon or assistant.	
Biologically Based Mental Illness - Inpatient - Outpatient - Office	90% 90% 100%*	80% 80% 80%	Limited to 30 days per calendar year. Limited to 52 visits per calendar year. Outpatient and Office limit combined. *Subject to Physician's Office Co-Pay.	
Birthing Centers	90%	80%		
Cardiac Rehabilitation Services	90%	80%	Benefits are limited to phase I and phase II services. Prior approval recommended for more than 18 sessions.	
Chiropractic Care	100%*	80%	*Subject to Physician's Office Co-Pay.	
Dental Benefits (1)	90%	80%	See additional information at the end of this benefit summary.	
Diabetes Education and Supplies (2)	90%	80%	See additional information at the end of this benefit summary.	
Durable Medical Equipment	90%	80%	Rental limited to purchase price.	
Emergency Room*	90%	90%		
Hemodialysis	90%	80%	Limited to hospital inpatient services or outpatient services in a Medicare approved dialysis center.	

* If emergency room care is provided for an accident or medical emergency, services performed by a non-PPO provider are considered at the PPO benefit level.

Services provided in a physician's office are subject to the office services co-pay. Then non-PPO services are subject to cost-sharing.

BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS (Cont.)	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Home Health Care Services (3)	90%	80%	See additional information at the end of this benefit summary. Preadmission Certification required.	
Home Infusion	90%	80%	Preadmission Certification required.	
Hospice Care	90%	80%	Pre-certification required. Respite care is limited to 15 inpatient and 15 outpatient days. These must be used in increments of 5 days or less. Bereavement counseling is limited to 5 visits.	
Hospital Benefits	90%	80%		
Infertility Benefits (4)	90%	80%	Includes infertility drugs. Limited to \$25,000 per lifetime. Prior approval is recommended. Does not apply to the out-of-pocket maximum. See additional information at the end of this summary.	
Inpatient-Hospital Physician Visits	90%	80%	Limited to one visit per specialty per day. Includes consultations.	
Outpatient-Hospital Physician Visits	90%	80%		
Maternity-Benefits - Post-partum RN visit	90% 100%	80% 100%	Deductible waived for the following: 1 home visit if mother/baby discharged sooner than 48 hours following a vaginal delivery or 96 hours following a C-section.	
- Inpatient newborn care	90%	80%		
Mental Health/Chemical Dependency - Inpatient - Outpatient	90% 90%	80% 80%	Limited to 30 days per calendar year. Limited to 30 visits per calendar year.	
Morbid Obesity (5)	90%	80%	Prior approval is required. See additional information at the end of this benefit summary.	
Organ Transplant Benefits	90%	80%	Prior approval is recommended. Covered transplant procedures: Autologous/allogeneic bone marrow (as indicated by this plan), heart, heart/lung, lung, pancreas, kidney, pancreas/kidney, small bowel, prosthetic lenses, liver and other non-experimental transplants as approved by this Plan. Coverage is also provided for corneal grafts. No coverage is provided for artificial or non-human organs. Cadaver organ procurement costs are limited to \$20,000 per transplant. Donor search costs for bone marrow/stem cell transfer services are limited to \$20,000 per transfer. Ambulance transportation costs to the transplant facility are limited to \$10,000 per transplant. Donor charges incurred by a member of this plan if not covered by the recipient's coverage.	
Outpatient Diagnostic X-Ray and Laboratory Benefits* (includes hospital outpatient, office and independent radiology and pathology facilities) - MRI, MRA, CT scan and ultrasound services - All other x-ray and laboratory services	90% 100%	80% 100%	Infertility related services will accumulate toward the infertility lifetime maximum. Calendar year deductible applies. Physician's Office co-pay and calendar year deductible waived.	
Physician Office Services	100%*	80%	*Subject to Physician's Office Co-Pay.	
Prescription Drugs (the Pharmacy Benefit Manager)	80%	80%	Includes coverage for insulin, insulin supplies and syringes, oral contraceptives, Viagra, Minoxidil, Propecia, and Retin-A as indicated in the SPD.	

BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS (Cont.)	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Private Duty Nursing	90%	80%	RN and LPN services are covered. Preadmission Certification required.	
Radiation and Chemotherapy	90%	80%		
Routine Mammograms	100%	100%	Calendar year deductible waived. Limited to one per calendar year.	
Routine Physical Exams	100%*	80%	Limited to individuals age 7 and over and to one per calendar year. Includes related services (x-rays, lab work, pap smears, and immunizations). *Subject to Physician's Office Co-Pay.	
Routine Vision Care	100%	100%	Limited to 1 exam per calendar year.	
Skilled Nursing Facility Benefits	90%	80%		
Surgery	90%	80%		
Temporomandibular Joint Dysfunction (TMJ)	90%	80%	Prior approval recommended. Benefits do not include manipulations, dental extractions, or orthodontic treatment.	
Therapies - Physical Therapy - Speech Therapy - Occupational Therapy - Inhalation/Respiratory Therapy	90%	80%	Prior approval recommended. Occupational therapy supplies are not covered.	
Well Child Care/Immunizations	100%	80%	Calendar year deductible waived. Limited to children under age 7. Includes physical examinations, developmental assessments, and immunizations.	
PLAN PAYS				
Lifetime Medical Maximum	\$4,000,000			

Services provided in a physician's office are subject to the office services co-pay. Then non-PPO services are subject to coinsurance. When no providers practicing in a particular medical specialty are participating with the PPO network, services performed by these providers will be considered at the PPO benefit level.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS	PATIENT'S LIABILITY	GENERAL PLAN LIMITS
Out-of-Pocket Maximum: (per calendar year) - per Individual	\$1,000	
Retail - Generic - Brand Formulary - Brand Non-Formulary Mail Order - Generic - Brand Formulary - Brand Non-Formulary	\$0 Co-Pay \$15 Co-Pay \$35 Co-Pay \$0 Co-Pay \$35 Co-Pay \$85 Co-Pay	Per prescription or refill. Per prescription or refill. Per prescription or refill. Limited to a 90-day supply. Per prescription or refill. Per prescription or refill. Per prescription or refill.