AMENDMENT ONE
DELAWARE COUNTY GOVERNMENT
EMPLOYEE BENEFIT PLAN
Effective October 1, 2010

ORIGINAL

BY THIS AGREEMENT, the Delaware County Government Employee Benefit Plan effective August 1, 2010 is hereby amended as follows effective October 1, 2010:

1. **On page 4 in Section <u>Continuation of Coverage for Retirees</u> the following language is DELETED:**

   Retirees may remain eligible under this Plan as long as the coverage remains a part of the County's group plan of insurance.

   The following language is SUBSTITUTED therein:

   Retirees may remain eligible for medical and dental coverage under this Plan until Medicare Eligible, at which time such Retiree shall become covered under the Medicare Carveout Policy purchased by the Company. Notwithstanding the above, dental coverage for such Retiree will continue to be provided under this Plan.

2. **On pages 10-13 the BENEFIT AND INFORMATION GRID is DELETED in its entirety and the following language is SUBSTITUTED therein:**

	Encircle (Facility) In-Network Level	**Encore In-Network Level**	**Out-of-Network Level**
Calendar Year Deductible	$200 per Person $400 per Family Unit	$300 per Person $600 per Family Unit	$400 per Person $800 per Family Unit
Calendar Year Out of Pocket Maximum *(Excluding Deductible)*	$550 per Person $1,100 Per Family Unit	$1,100 Per Person $2,200 per Family Unit	$2,200 per Person $4,400 per Family Unit
Note: Copayments do not apply to the Out of Pocket Maximum. Encircle and Encore level Deductibles and Out of Pocket Maximums Accumulate together. The Out-Net-Work Deductible and Out-of-Pocket must be satisfied separately.			
Coinsurance	90% - Unless otherwise noted	80% -- unless otherwise noted	70% -- unless otherwise noted All Out-of-Network charges limited to Usual and Customary
Lifetime Plan Maximum	$5,000,000		
PRE-EXISTING CONDITION LIMITATIONS			
Permissible only if the limitation relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period before the plan participation started. The pre-existing condition limitation will no longer apply if the person is covered under the Plan for a period of time equal to twelve (12) consecutive months minus the covered person's period of Creditable Coverage.			
PRE-CERTIFICATION REQUIREMENTS			
Pre-admission certification is <u>required</u> for all Inpatient admissions and surgeries, Outpatient surgeries (other than in physician's office), Outpatient MRIs, CT Scans, and PET Scans. Further, it is <u>recommended</u> to certify in advance any First Trimester Maternity and Outpatient chemotherapy and radiation therapy. **CALL 800-944-9401**			

	Encircle (Facility) In-Network Level	Encore In-Network Level	Out-of-Network Level
HOSPITAL SERVICES			
Hospital Inpatient Facility Charges	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
Hospital Outpatient Facility Charges	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
Outpatient Hosptial Labs, X-ray, Nuclear Imaging	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
PHYSICIAN SERVICES			
Inpatient Physician and Physician Other than Office Charges *(including anesthesia)*	Not currently available	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
Physician Office Visit Charges *(Office visit charge only)*	Not currently available	$20 Copay, then 100% paid by Plan, Deductible does not apply	After Deductible 70% paid by Plan
All Services in Physician Office *(Including Allergy injections, serums and testing)*	Not currently available	After Deductible 90% paid by Plan	After Deductible 70% paid by Plan
EMERGENCY SERVICES			
Emergency Room Services *(Copay waived if admitted)*	$100 Copay, then After Deductible 90% paid by Plan	$100 Copay, then after Deductible, 80% paid by Plan	$100 Copay, then after Deductible 70% paid by Plan
Urgent Care Center *(Office visit charge only)*	Not currently available	$35 Copay, then 100% paid by Plan, Deductible does not apply.	After Deductible 70% paid by Plan
Ambulance	Not currently available	After Deductible 90% paid by Plan	After Deductible 70% paid by Plan
PREVENTIVE/WELLNESS CARE			
Well Baby/Well Child Care	Not currently available	$20 Copay, then 100% paid by Plan, Deductible does not apply	After Deductible 70% paid by Plan
Immunizations *(that have in effect a recommendation from the Centers of Disease Control with respect to the individual and those required for school)*	Not currently available	$20 Copay, then 100% paid by Plan, Deductible does not apply	After Deductible 70% paid by Plan

	Encircle (Facility) In-Network Level	Encore In-Network Level	Out-of-Network Level
PREVENTIVE/WELLNESS CONTINUED			
Adult Routine Exams Testing and Screenings *(Includes related labs and x-rays)*	Not currently available	$20 Copay, then 100% paid by Plan, Deductible does not apply	After Deductible 70% paid by Plan
Routine and Non-Routine Mammogram	Not currently available	$20 Copay, then 100% paid by Plan, Deductible does not apply	After Deductible 70% paid by Plan
Diabetic Self Management Training	Not currently available	$20 Copay, then 100% paid by Plan, Deductible does not apply	After Deductible 70% paid by Plan
OTHER MEDICAL SERVICES			
Maternity Services *(for all covered persons)*	Same as any other illness	Same as any other illness	Same as any other illness
Medical Supplies/ Durable Medical Equipment/ Orthotics/ Prosthetics	Not currently available	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
Extended Care / Skilled Nursing/ Rehabilitation Facility *(Limited to 60 days per Calendar Year combined)*	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
Hospice Facility *(with 6 month life expectancy)*	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
Hospice Non Facility Services *(with 6 month life expectancy)*	Not currently available	After Deductible 90% paid by Plan	After Deductible 70% paid by Plan
Home Health Care	Not currently available	After Deductible 90% paid by Plan ***unlimited***	After Deductible 70% paid by Plan ***Limited to 30 visits per Calendar Year***
Physical and Occupational Therapy *(Limited to 60 visits per Calendar Year combined)*	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
Speech Therapy Limited to 20 visits per Calendar Year)	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
All Other Therapy Services *(Dialysis, Chemotherapy, Radiation Therapy)*	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan

	Encircle (Facility) In-Network Level	Encore In-Network Level	Out-of-Network Level
Chiropractic Care ***(copay includes office visit only. All other services subject to Deductible and Coinsurance)***	Not currently available	$20 Copay, then 100% paid by Plan, Deductible does not apply	After Deductible 70% paid by Plan
Organ and Tissue Transplants ***(Limited to $1,000,000 Lifetime maximum)***	After Deductible 90% paid by Plan	After Deductible 80% paid by Plan	After Deductible 70% paid by Plan
PRESCRIPTION DRUG BENEFIT			
In-Network Retail Prescription Drugs ***(30 day supply)***	Copays for: Generic Preferred Brand Non Preferred Brand	 $5 $25 $35	
In-Network Retail and Mail Order Specialty Drugs ***(30 day supply)***	Copays for: Generic Preferred Brand Non Preferred Brand	 $5 $25 $35	
In-Network Mail Order Prescription Drugs ***(90 day supply)***	Copays for: Generic Preferred Brand Non Preferred Brand	 $10 $50 $70	
Non Network Prescription Drugs	After Deductible, 50% reimbursed by Plan		
Certain diabetic and asthmatic supplies are covered in full with no copayment when obtained from an In-Network pharmacy. These supplies are covered as Medical Supplies or Durable Medical Equipment if obtained from an Out-of-Network Pharmacy. **90 day prescriptions that cannot be dispensed via mail order may be filled at a Retail pharmacy, subject to the mail order 90 day supply copay. Also birth control medications may be filled at Retail pharmacy.**			
DENTAL PLAN BENEFIT			
Calendar Year Deductible	None		
Calendar Year Maximum	$1,500 per Covered Person		
Lifetime Orthodontia Maximum	$1,000 per Covered Person Does not apply to Calendar Year Maximum Orthodontia services limited to children under age 19		
Reimbursement Schedule	Class I - Diagnostic/Preventive Class II -- Basic Class III -- Major Class IV -- Orthodontia	100% paid by Plan 80% paid by Plan 50% paid by Plan 50% paid by Plan	

This benefit and information grid is a summary of the plan benefits. For more complete information, please see sections *Covered Services, Prescription Drug Benefits, Dental Benefits,* and *Services Not Covered.*

IN WITNESS WHEREOF, Delaware County Government (The Company and Plan Administrator) and Unified Group Services, Inc. (the Plan Supervisor) have executed this Delaware County Government Employee Benefit Plan Amendment One Agreement this _____ day of _____, 2010.

BY: Delaware County Government

(Signature)

(Printed)

WITNESS:

(Signature)

(Printed)