Your Anthem Benefits

Anthem.

MSD OF WAYNE TOWNSHIP
Blue Preferred® Primary (HMO)
Summary of Benefits, Effective January 1, 2007

COVERED BENEFITS	NETWORK (MEMBER'S RESPONSIBILITY)
Out-of-Pocket Maximum (Single/Family)	$3,000/$6,000
Office Visit • Including Allergy – testing and treatment – serum and injections[1]	$25 per visit
Preventive Care	$25 per visit. Included with no age or dollar limits; no Non-network benefits apply*. Preventive care includes: medical history, mammograms[1], pelvic exams and Pap tests, immunizations[1], routine and annual diabetic eye exams and hearing exams.
Maternity Services	$250 (per admission)
Inpatient Services	$250 per admission
Outpatient Facility Services	$75
Professional/Home Care (Inpatient/Outpatient)	Covered in full
Emergency and Urgent Care:	
Emergency Care in ER Room *(covers all services, waived if admitted)*	$100
Urgent Care Facility	$35
Hospice/Ambulance	Covered in full
Medical Supplies, Equipment and Appliances	20%
Outpatient Therapy Visit Limits	
Physical/Occupational	60 visits; same copay as office visit
Spinal Manipulation	12 visits; same copay as office visit
Speech	20 visits; same copay as office visit
Mental Health and Substance Abuse[2]	Covered as any other illness. Subject to same copays and maximums.
Lifetime Maximum	$5 million (Excluding human organ and tissue transplants)
Human Organ and Tissue Transplants[3]	Covered in full Network
Prescription Drug Options:	**Network**
Network Retail Pharmacies: (30-day supply)	$15 Formulary generic/$30 Formulary brand $60 Non-formulary generic/ brand
Anthem Rx Direct Mail Service: (90-day supply)	$30 Formulary generic/$60 Formulary brand $120 Non-formulary generic/brand

**Non-network services are covered only with authorization by the Plan, except in medical emergencies.*

Notes:

- *All copayments (except prescription drug and human organ and tissue transplants, excluding kidney and cornea) apply toward the out-of-pocket maximums.*
- *Dependent age: to the end of the calendar year of age 19; age 24 if dependent qualifies as a full-time student.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies.*
- *Office visit also includes office surgeries and preconception care/education.*

[1] *These covered services are covered in full if you have a flat dollar copayment and if rendered without an office visit.*

[2] *Mental health/substance abuse must be authorized by the mental health administrator for services to be covered.*

[3] *Human organ and tissue transplants (except kidney and cornea) are covered in full Network. Subject to a separate $1 million lifetime maximum. Kidney and cornea are covered same as any other illness and subject to the medical lifetime maximum.*

[4] *If applicable, all prescription drug expenses (Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.*

Pre-existing Period Limit:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPPA Portability requirements):

Non-late enrollee:	*12 months after the member's enrollment date*
Late enrollee:	*18 months after the member's enrollment date*

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period ending on the member's enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Anthem Benefits

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MSD OF WAYNE TOWNSHIP
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2007

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)	
Deductible (Single/Family) *(Applies only to percent (%) copayments)*	$250/$500 Network/$500/$1,000 Non-network	
Out-of-Pocket Maximum (Single/Family)	$1,500/$3,000 Network/$3,000/$6,000 Non-network	
Office Services • Including Allergy – testing and treatment – serum and injections[1]	$20 Network/30% Non-network Per Visit	
Preventive Care	$20 Network/30% Non-network Per Visit. Included with no age or dollar limits; Non-network benefits apply. Preventive care includes: medical history, mammograms[1], pelvic exams and Pap tests, immunizations[1], routine and annual diabetic eye exams and hearing exams.	
Maternity Services	10% Network/30% Non-network	
Inpatient Services	10% Network/30% Non-network per admission	
Outpatient Facility Services	10% Network/30% Non-network	
Professional/Home Care (Inpatient/Outpatient)	10% Network/30% Non-network	
Emergency and Urgent Care:		
Emergency Care in ER Room *(covers all services, waived if admitted)*	$75 Network or Non-network	
Urgent Care Facility	$35 Network or Non-network	
Hospice/Ambulance	Covered in full Network or Non-network	
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network	
Outpatient Therapy Visit Limits *(Limits apply to Network/Non-network combined visits.)*		
Physical/Occupational	60 Network and Non-network combined visits; same copay as office services	
Spinal Manipulation	12 Network and Non-network combined visits; same copay as office services	
Speech	20 Network and Non-network combined visits; same copay as office services	
Mental Health and Substance Abuse[2]	Covered as any other illness. Subject to same copays, deductibles and maximums.	
Lifetime Maximum	$5 million Network and Non-network combined (Excluding human organ and tissue transplants)	
Human Organ and Tissue Transplants[3]	Covered in full Network/50% Non-network (Does not count toward out-of-pocket maximum)	
Prescription Drug Options:	**Network**	**Non-network**
Network Retail Pharmacies: (30-day supply)	$15 generic/$30 brand $60 non-formulary generic/brand	50% Non-network
Anthem Rx Direct Mail Service: (90-day supply)	$30 formulary generic/$60 formulary brand $120 non-formulary generic/brand	Not covered Non-network

Notes:

- *The deductibles and copayments (except prescription drug and human organ and tissue transplants, excluding kidney and cornea) apply toward the out-of-pocket maximums.*
- *The deductible(s) apply only to covered services listed with a percentage (%) copayment.*
- *Network and Non-network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent age: to the end of the calendar year of age 19; age 24 if dependent qualifies as a full-time student.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies.*
- *Office services also includes office surgeries and preconception care/education.*

[1] *These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.*

[2] *Mental health/substance abuse must be authorized by the mental health administrator for services to be covered at the highest benefit level.*

[3] *Human organ and tissue transplants (except kidney and cornea) are covered in full Network; 50% Non-network. Does not count toward the out-of-pocket maximum. Subject to a separate $1 million lifetime maximum Network and Non-network combined. Kidney and cornea are covered same as any other illness and subject to the medical lifetime maximum.*

[4] *If applicable, all prescription drug expenses (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.*

Non-network Limits:

- *Physical medicine and rehabilitation limited to 60 days per calendar year* ***(Network and Non-network combined).***
- *Home care is limited to 30 visits per calendar year.*

Precertification:

Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Period Limit:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPPA Portability requirements):

Non-late enrollee:	*12 months after the member's enrollment date*
Late enrollee:	*18 months after the member's enrollment date*

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period ending on the member's enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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Your Anthem Benefits

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MSD of Wayne Township
Blue Access℠ for Health Savings Accounts Option H6
Summary of Benefits, Effective January 1, 2007

Covered Benefits	Network	Non-Network
Deductible (Single/Family) Family coverage requires the family deductible to be met before coinsurance applies. The single deductible **does not** apply to family coverage. *(This only applies to non-embedded deductible designs)*	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit (Single/Family)	Single: $2,000 Family: $4,000	Single: $8,000 Family: $16,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) • Including Office Surgeries and allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Annual Vision and Hearing exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 No copayment/coinsurance No copayment/coinsurance	 30% 30%
Emergency and Urgent Care • **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)* • **Urgent Care Center Services**	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services *(including but not limited to)*: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (Network/Non-network combined) $4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) Prosthetic Devices $4,000 benefit maximum • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply)		
• Physician Home and Office Visits (PCP/SCP)	0%	30%
• Other Outpatient Services @ Hospital/Alternative Care Facility	0%	30%
Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits		
Behavioral Health Services:		
Mental Health and Substance Abuse[1] (limits and maximums apply)		
• Inpatient Facility Services	0%	30%
• Physician Home and Office Visits (PCP/SCP)	0%	30%
• Other Outpatient Services @ Hospital/Alternative Care Facility	0%	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs **Network Tier structure equals 1/2/3 (and 4, if applicable)**		
• **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	0%	30%[2]
• **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip	0%	Not covered
Lifetime Maximum (Combined Network and Non-network)[3]		
Medical	$5 million	$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Not covered	Not covered

Notes:

- *All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).*
- *Deductible(s) apply to covered services listed with a percentage (%) coinsurance including prescription drugs.*
- *Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent Age: to the end of the calendar year which the child attains age 19; or to the end of the calendar year which the child attains age 24 if the child qualifies as a full-time student.*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.*
- *PCP is a Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.*
- *SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.*
- *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.*
- *Benefit period = calendar year*

[1] *We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*

[2] *Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.*

[3] *Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid*

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements)
12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Anthem Benefits

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MSD of Wayne Township
Blue Preferred® Primary (HMO)
Summary of Benefits, Effective January 1, 2008

Covered Benefits	Network
Deductible (Single/Family)	$250/$500
Out-of-Pocket Limit (Single/Family)	$3,000/$6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • routine and non-routine mammograms (regardless of outpatient setting) • diabetic education (regardless of outpatient setting) • certain medical nutritional therapy (regardless of outpatient setting)	$35 No copayment/coinsurance (if billed with office visit copay, then copay applies) No copayment/coinsurance (if billed with office visit copay, then copay applies) $35 $35 $35
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Routine Vision and Hearing exams • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 $35 $150
Emergency and Urgent Care • **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)* • **Urgent Care Center Services**	 $100 $50
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	No copayment/coinsurance
Inpatient Facility Services Unlimited days except for: • Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • Unlimited days for skilled nursing facility	$500
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	$250
Other Outpatient Services *(including but not limited to):* • Non-Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. (regardless of place of service) • Home Care Services Unlimited visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics Unlimited benefit maximum (excluding Prosthetic Devices and Medical Supplies) • Prosthetic Devices Unlimited benefit maximum • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	$150 20% 20% 20% $150 No copayment/coinsurance No copayment/coinsurance

Covered Benefits	Network
Outpatient Therapy Services (limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy/Occupational therapy: 60 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits	$35
Behavioral Health Services: **Mental Health and Substance Abuse[2]** **(limits and maximums apply)** • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Outpatient Services @ Hospital/Alternative Care Facility	 $500 $35 $150
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance
Prescription Drugs Network **Tier structure equals 1/2/3 (and 4, if applicable)** • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip **Medicare Rx - Wrap** **Specialty Medications** must be obtained via our Specialty Pharmacy network.	 $20/$40/$80 $40/$80/$160
Lifetime Maximum[4] Medical Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	 $5 million Unlimited

Notes:

- *Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.*
- *Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.*
- *Dependent age: to the end of calendar year which the child attains age 24*
- *Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount.*
- *PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.*
- *SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.*
- *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.*
- *Benefit period = calendar year*

[1] *These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.*
[2] *We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*
[3] *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*
[4] *Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.*

Pre-existing Exclusion Period:
We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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MSD of Wayne Township
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2008

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)	
Deductible (Single/Family) *(Applies only to percent (%) copayments)*	$500/$1,000 Network/$1,000/$2,000 Non-network	
Out-of-Pocket Maximum (Single/Family)	$2,000/$4,000 Network/$4,000/$8,000 Non-network	
Office Services • Including Allergy – testing and treatment – serum and injections[1]	$35 Network/40% Non-network Per Visit	
Preventive Care	$35 Network/40% Non-network Per Visit. Included with no age or dollar limits; Non-network benefits apply. Preventive care includes: medical history, mammograms[1], pelvic exams and Pap tests, immunizations[1], routine and annual diabetic eye exams and hearing exams.	
Maternity Services	20% Network/40% Non-network	
Inpatient Services	20% Network/40% Non-network per admission	
Outpatient Facility Services	20% Network/40% Non-network	
Professional/Home Care (Inpatient/Outpatient)	20% Network/40% Non-network	
Emergency and Urgent Care:		
Emergency Care in ER Room *(covers all services, waived if admitted)*	$150 Network or Non-network	
Urgent Care Facility	$50 Network or Non-network	
Hospice/Ambulance	Covered in full Network or Non-network	
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network	
Outpatient Therapy Visit Limits *(Limits apply to Network/Non-network combined visits.)*		
Physical/Occupational	60 Network and Non-network combined visits; same copay as office services	
Spinal Manipulation	12 Network and Non-network combined visits; same copay as office services	
Speech	20 Network and Non-network combined visits; same copay as office services	
Mental Health and Substance Abuse[2]	Covered as any other illness. Subject to same copays, deductibles and maximums.	
Lifetime Maximum	$5 million Network and Non-network combined (Excluding human organ and tissue transplants)	
Human Organ and Tissue Transplants[3]	Covered in full Network/50% Non-network (Does not count toward out-of-pocket maximum)	
Prescription Drug Options:	**Network**	**Non-network**
Network Retail Pharmacies: (30-day supply)	$20 formulary generic/$40 formulary brand $80 non-formulary generic/brand	50% Non-network
Anthem Rx Direct Mail Service: (90-day supply)	$40 formulary generic/$80 formulary brand $160 non-formulary generic/brand	Not covered Non-network

Notes:

- *The deductibles and copayments (except prescription drug and human organ and tissue transplants, excluding kidney and cornea) apply toward the out-of-pocket maximums.*
- *The deductible(s) apply only to covered services listed with a percentage (%) copayment.*
- *Network and Non-network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent age: to the end of the calendar year of age 24.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies.*
- *Office services also includes office surgeries and preconception care/education.*

1 *These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.*

2 *We encourage you to contact our Mental Health Subcontractor to assure the use of appropriate procedures, settings and Medical Necessity. Refer to the Schedule of Benefits for limitations.*

3 *Human organ and tissue transplants (except kidney and cornea) are covered in full Network; 50% Non-network. Does not count toward the out-of-pocket maximum. Subject to a separate $1 million lifetime maximum Network and Non-network combined. Kidney and cornea are covered same as any other illness and subject to the medical lifetime maximum.*

4 *If applicable, all prescription drug expenses (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.*

Non-network Limits:

- *Physical medicine and rehabilitation limited to 60 days per calendar year* ***(Network and Non-network combined).***
- *Home care is limited to 30 visits per calendar year.*

Precertification:

Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Period Limit:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA Portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the member's enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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Blue Access℠ for Health Savings Accounts Option H6
Summary of Benefits, Effective January 1, 2008

Covered Benefits	Network	Non-Network
Deductible (Single/Family) Family coverage requires the family deductible to be met before coinsurance applies. The single deductible **does not** apply to family coverage. *(This only applies to non-embedded deductible designs)*	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit (Single/Family)	Single: $2,000 Family: $4,000	Single: $8,000 Family: $16,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) • Including Office Surgeries and allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Annual Vision and Hearing exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 No copayment/coinsurance No copayment/coinsurance	 30% 30%
Emergency and Urgent Care • **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)* • **Urgent Care Center Services**	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services *(including but not limited to)*: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (Network/Non-network combined) $4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) Prosthetic Devices $4,000 benefit maximum • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits	 0% 0%	 30% 30%
Behavioral Health Services: **Mental Health and Substance Abuse**[1] Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 0% 0% 0%	 30% 30% 30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs **Network Tier structure equals 1/2/3 (and 4, if applicable)** • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip Medicare Rx - Wrap	 0% 0%	 30%[2] Not covered
Lifetime Maximum (Combined Network and Non-network)[3] Medical Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	 $5 million Not covered	 $5 million Not covered

Notes:

- *All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).*
- *Deductible(s) apply to covered services listed with a percentage (%) coinsurance including prescription drugs.*
- *Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent Age: to the end of the calendar year which the child attains age 24 .*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.*
- *PCP is a Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.*
- *SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.*
- *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips*
- *Benefit period = calendar year*

[1] *We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*

[2] *Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.*

[3] *Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.*

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):
12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Anthem Benefits

Anthem.

MSD of Wayne Township
Blue Preferred® Primary (HMO)
Summary of Benefits, Effective January 1, 2009

Covered Benefits	Network
Deductible (Single/Family)	$250/$500
Out-of-Pocket Limit (Single/Family)	$3,000/$6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • routine and non-routine mammograms (regardless of outpatient setting) • diabetic education (regardless of outpatient setting) • certain medical nutritional therapy (regardless of outpatient setting)	$35 No copayment/coinsurance (if billed with office visit copay, then copay applies) No copayment/coinsurance (if billed with office visit copay, then copay applies) $35 $35 $35
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Routine Vision and Hearing exams • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 $35 $150
Emergency and Urgent Care • **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)* • **Urgent Care Center Services**	 $100 $50
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	No copayment/coinsurance
Inpatient Facility Services Unlimited days except for: • Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • Unlimited days for skilled nursing facility	$500
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	$250
Other Outpatient Services *(including but not limited to):* • Non-Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. (regardless of place of service) • Home Care Services Unlimited visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics Unlimited benefit maximum (excluding Prosthetic Devices and Medical Supplies) • Prosthetic Devices Unlimited benefit maximum • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	$150 20% 20% 20% $150 No copayment/coinsurance No copayment/coinsurance

Covered Benefits	Network
Outpatient Therapy Services (limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy/Occupational therapy: 60 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits	$35
Behavioral Health Services: **Mental Health and Substance Abuse[2]** **(limits and maximums apply)** • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Outpatient Services @ Hospital/Alternative Care Facility	 $600 $35 $150
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance
Prescription Drugs Network **Tier structure equals 1/2/3 (and 4, if applicable)** • **Network Retail Pharmacies:** (30-day supply) Diabetic Test Strip • **Anthem Rx Direct Mail Service:** (90-day supply) Diabetic Test Strip **Medicare Rx - Wrap** **Specialty Medications** must be obtained via our Specialty Pharmacy network.	 $20/$40/$80 No copayment/coinsurance $40/$80/$160 No copayment/coinsurance
Lifetime Maximum[4] Medical Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	 $5 million Unlimited

Notes:

- *Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.*
- *Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.*
- *Dependent age: to the end of calendar year which the child attains age 24*
- *Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount.*
- *PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.*
- *SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.*
- *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.*
- *Benefit period = calendar year*

[1]These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
[2]We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.
[3]Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
[4]Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Anthem Benefits

Anthem

MSD of Wayne Township
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2009

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)
Deductible (Single/Family) *(Applies only to percent (%) copayments)*	$500/$1,000 Network/$1,000/$2,000 Non-network
Out-of-Pocket Maximum (Single/Family)	$2,000/$4,000 Network/$4,000/$8,000 Non-network
Office Services • Including Allergy – testing and treatment – serum and injections[1]	$35 Network/40% Non-network Per Visit
Preventive Care	$35 Network/40% Non-network Per Visit. Included with no age or dollar limits; Non-network benefits apply. Preventive care includes: medical history, mammograms[1], pelvic exams and Pap tests, immunizations[1], routine and annual diabetic eye exams and hearing exams.
Maternity Services	20% Network/40% Non-network
Inpatient Services	20% Network/40% Non-network per admission
Outpatient Facility Services	20% Network/40% Non-network
Professional/Home Care (Inpatient/Outpatient)	20% Network/40% Non-network
Emergency and Urgent Care:	
Emergency Care in ER Room *(covers all services, waived if admitted)*	$150 Network or Non-network
Urgent Care Facility	$50 Network or Non-network
Hospice/Ambulance	Covered in full Network or Non-network
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network
Outpatient Therapy Visit Limits *(Limits apply to Network/Non-network combined visits.)*	
Physical/Occupational	60 Network and Non-network combined visits; same copay as office services
Spinal Manipulation	12 Network and Non-network combined visits; same copay as office services
Speech	20 Network and Non-network combined visits; same copay as office services
Mental Health and Substance Abuse[2]	Covered as any other illness. Subject to same copays, deductibles and maximums.
Lifetime Maximum	$5 million Network and Non-network combined (Excluding human organ and tissue transplants)
Human Organ and Tissue Transplants[3]	Covered in full Network/50% Non-network (Does not count toward out-of-pocket maximum)
Prescription Drug Options:	**Network** / **Non-network**
Network Retail Pharmacies: (30-day supply)	$20 formulary generic/$40 formulary brand $80 non-formulary generic/brand 50% Non-network
Anthem Rx Direct Mail Service: (90-day supply)	$40 formulary generic/$80 formulary brand $160 non-formulary generic/brand Not covered Non-network

Notes:

- *The deductibles and copayments (except prescription drug and human organ and tissue transplants, excluding kidney and cornea) apply toward the out-of-pocket maximums.*
- *The deductible(s) apply only to covered services listed with a percentage (%) copayment.*
- *Network and Non-network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent age: to the end of the calendar year of age 24.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies.*
- *Office services also includes office surgeries and preconception care/education.*

1 *These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.*

2 *We encourage you to contact our Mental Health Subcontractor to assure the use of appropriate procedures, settings and Medical Necessity. Refer to the Schedule of Benefits for limitations.*

3 *Human organ and tissue transplants (except kidney and cornea) are covered in full Network; 50% Non-network. Does not count toward the out-of-pocket maximum. Subject to a separate $1 million lifetime maximum Network and Non-network combined. Kidney and cornea are covered same as any other illness and subject to the medical lifetime maximum.*

4 *If applicable, all prescription drug expenses (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.*

Non-network Limits:

- *Physical medicine and rehabilitation limited to 60 days per calendar year* ***(Network and Non-network combined).***
- *Home care is limited to 30 visits per calendar year.*

Precertification:

Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Period Limit:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA Portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the member's enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Anthem Benefits

Anthem.

MSD of Wayne Township
Blue Access℠ for Health Savings Accounts Option H6
Summary of Benefits, Effective January 1, 2009

Covered Benefits	Network	Non-Network
Deductible (Single/Family) Family coverage requires the family deductible to be met before coinsurance applies. The single deductible **does not** apply to family coverage. *(This only applies to non-embedded deductible designs)*	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit (Single/Family)	Single: $2,000 Family: $4,000	Single: $8,000 Family: $16,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) • Including Office Surgeries and allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Annual Vision and Hearing exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 No copayment/coinsurance No copayment/coinsurance	 30% 30%
Emergency and Urgent Care • **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)* • **Urgent Care Center Services**	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services *(including but not limited to):* • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (Network/Non-network combined) $4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) Prosthetic Devices $4,000 benefit maximum • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)**		
• Physician Home and Office Visits (PCP/SCP)	0%	30%
• Other Outpatient Services @ Hospital/Alternative Care Facility	0%	30%
Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits		
Behavioral Health Services: **Mental Health and Substance Abuse**[1] Inpatient Facility Services		
• Physician Home and Office Visits (PCP/SCP)	0%	30%
• Other Outpatient Services @ Hospital/Alternative Care Facility	0%	30%
	0%	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs **Network Tier structure equals 1/2/3 (and 4, if applicable)**		
• **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	0%	30%[2]
• **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip Medicare Rx - Wrap	0%	Not covered
Lifetime Maximum (Combined Network and Non-network)[3]		
Medical	$5 million	$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Not covered	Not covered

Notes:

- *All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).*
- *Deductible(s) apply to covered services listed with a percentage (%) coinsurance including prescription drugs.*
- *Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent Age: to the end of the calendar year which the child attains age 24.*
- *No copay, coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.*
- *PCP is a Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.*
- *SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.*
- *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.*
- *Benefit period = calendar year*

[1]*We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*

[2]*Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.*

[3]*Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.*

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

Pre-existing Condition Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):
12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Anthem Benefits

Anthem.

MSD of Wayne Township
Blue Preferred® Primary (HMO)
Summary of Benefits, Effective January 1, 2010

Covered Benefits	Network
Deductible (Single/Family)	$250/$500
Out-of-Pocket Limit (Single/Family)	$3,000/$6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$35
• allergy injections (PCP and SCP)	No copayment/coinsurance (if billed with office visit copay, then copay applies)
• allergy testing	No copayment/coinsurance (if billed with office visit copay, then copay applies)
• routine and non-routine mammograms (regardless of outpatient setting)	$35
• diabetic education (regardless of outpatient setting)	$35
• certain medical nutritional therapy (regardless of outpatient setting)	$35
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Routine Vision and Hearing exams	
• Physician Home and Office Visits (PCP/SCP)	$35
• Other Outpatient Services @ Hospital/Alternative Care Facility	$150
Emergency and Urgent Care	
• **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)*	$100
• **Urgent Care Center Services**	$50
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	No copayment/coinsurance
Inpatient Facility Services Unlimited days except for: • Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • Unlimited days for skilled nursing facility	$500
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	$250
Other Outpatient Services *(including but not limited to):*	$150
• Non-Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services, (regardless of place of service)	
• Home Care Services Unlimited visits (excludes IV Therapy)	20%
• Durable Medical Equipment and Orthotics Unlimited benefit maximum (excluding Prosthetic Devices and Medical Supplies)	20%
• Prosthetic Devices Unlimited benefit maximum	20%
• Physical Medicine Therapy Day Rehabilitation programs	$150
• Hospice Care	No copayment/coinsurance
• Ambulance Services	No copayment/coinsurance

Covered Benefits	Network
Outpatient Therapy Services (limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy/Occupational therapy: 60 visits • Manipulation therapy: 12 visits • Speech therapy 20 visits	$35
Behavioral Health Services: **Mental Health and Substance Abuse[2]** **(limits and maximums apply)** • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Outpatient Services @ Hospital/Alternative Care Facility	 $500 $35 $150
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance
Prescription Drugs Network **Tier structure equals 1/2/3 (and 4, if applicable)** • **Network Retail Pharmacies:** (30-day supply) Diabetic Test Strip • **Anthem Rx Direct Mail Service:** (90-day supply) Diabetic Test Strip **Medicare Rx - Wrap** **Specialty Medications** must be obtained via our Specialty Pharmacy network.	 $20/$40/$80/$80 No copayment/coinsurance $40/$80/$160/$160 No copayment/coinsurance
Lifetime Maximum[4] Medical Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	 $5 million Unlimited

Notes:

- *Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.*
- *Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.*
- *Dependent age: to the end of calendar year which the child attains age 24*
- *Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount.*
- *PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.*
- *SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.*
- *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.*
- *Benefit period = calendar year*

[1]These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
[2]We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.
[3]Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
[4]Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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Your Anthem Benefits

Anthem

MSD of Wayne Township
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2010

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)	
Deductible (Single/Family) *(Applies only to percent (%) copayments)*	$500/$1,000 Network/$1,000/$2,000 Non-network	
Out-of-Pocket Maximum (Single/Family)	$2,000/$4,000 Network/$4,000/$8,000 Non-network	
Office Services • Including Allergy – testing and treatment – serum and injections[1]	$35 Network/40% Non-network Per Visit	
Preventive Care	$35 Network/40% Non-network Per Visit. Included with no age or dollar limits; Non-network benefits apply. Preventive care includes: medical history, mammograms[1], pelvic exams and Pap tests, immunizations[1], routine and annual diabetic eye exams and hearing exams.	
Maternity Services	20% Network/40% Non-network	
Inpatient Services	20% Network/40% Non-network per admission	
Outpatient Facility Services	20% Network/40% Non-network	
Professional/Home Care (Inpatient/Outpatient)	20% Network/40% Non-network	
Emergency and Urgent Care:		
Emergency Care in ER Room *(covers all services, waived if admitted)*	$150 Network or Non-network	
Urgent Care Facility	$50 Network or Non-network	
Hospice/Ambulance	Covered in full Network or Non-network	
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network	
Outpatient Therapy Visit Limits *(Limits apply to Network/Non-network combined visits.)*		
Physical/Occupational	60 Network and Non-network combined visits; same copay as office services	
Spinal Manipulation	12 Network and Non-network combined visits; same copay as office services	
Speech	20 Network and Non-network combined visits; same copay as office services	
Mental Health and Substance Abuse[2]	Covered as any other illness. Subject to same copays, deductibles and maximums.	
Lifetime Maximum	$5 million Network and Non-network combined (Excluding human organ and tissue transplants)	
Human Organ and Tissue Transplants[3]	Covered in full Network/50% Non-network (Does not count toward out-of-pocket maximum)	
Prescription Drug Options:	**Network**	**Non-network**
Network Retail Pharmacies: (30-day supply)	$20 formulary generic/$40 formulary brand $80 non-formulary generic/brand	50% Non-network
Anthem Rx Direct Mail Service: (90-day supply)	$40 formulary generic/$80 formulary brand $160 non-formulary generic/brand	Not covered Non-network

Notes:

- *The deductibles and copayments (except prescription drug and human organ and tissue transplants, excluding kidney and cornea) apply toward the out-of-pocket maximums.*
- *The deductible(s) apply only to covered services listed with a percentage (%) copayment.*
- *Network and Non-network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent age: to the end of the calendar year of age 24.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies.*
- *Office services also includes office surgeries and preconception care/education.*

1 *These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.*

2 *We encourage you to contact our Mental Health Subcontractor to assure the use of appropriate procedures, settings and Medical Necessity. Refer to the Schedule of Benefits for limitations.*

3 *Human organ and tissue transplants (except kidney and cornea) are covered in full Network; 50% Non-network. Does not count toward the out-of-pocket maximum. Subject to a separate $1 million lifetime maximum Network and Non-network combined Kidney and cornea are covered same as any other illness and subject to the medical lifetime maximum.*

4 *If applicable, all prescription drug expenses (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.*

Non-network Limits:

- *Physical medicine and rehabilitation limited to 60 days per calendar year* ***(Network and Non-network combined).***
- *Home care is limited to 30 visits per calendar year.*

Precertification:

Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Period Limit:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA Portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the member's enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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Your Anthem Benefits

Anthem.

MSD of Wayne Township
Blue Access℠ for Health Savings Accounts Option H6
Summary of Benefits, Effective January 1, 2010

Covered Benefits	Network	Non-Network
Deductible (Single/Family) Family coverage requires the family deductible to be met before coinsurance applies. The single deductible **does not** apply to family coverage. *(This only applies to non-embedded deductible designs)*	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit (Single/Family)	Single: $2,000 Family: $4,000	Single: $8,000 Family: $16,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) • Including Office Surgeries and allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Annual Vision and Hearing exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 No copayment/coinsurance No copayment/coinsurance	 30% 30%
Emergency and Urgent Care • **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)* • **Urgent Care Center Services**	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services *(including but not limited to)*: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (Network/Non-network combined) $4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) Prosthetic Devices $4,000 benefit maximum • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits	 0% 0%	 30% 30%
Behavioral Health Services: **Mental Health and Substance Abuse**[1] Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 0% 0% 0%	 30% 30% 30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs **Network Tier structure equals 1/2/3 (and 4, if applicable)** • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip Medicare Rx - Wrap	 0% 0%	 30%[2] Not covered
Lifetime Maximum (Combined Network and Non-network)[3] Medical Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	 $5 million Not covered	 $5 million Not covered

Notes:

- *All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).*
- *Deductible(s) apply to covered services listed with a percentage (%) coinsurance including prescription drugs.*
- *Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent Age: to the end of the calendar year which the child attains age 24.*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment*
- *PCP is a Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.*
- *SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.*
- *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.*
- *Benefit period = calendar year*

[1] *We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*

[2] *Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.*

[3] *Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.*

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):
12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Summary of Benefits

Anthem

MSD of Wayne Township
Blue Preferred® (HMO)
Effective January 1, 2011

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits

Covered Benefits	Network
Deductible (Single/Family)	$250/$500
Out-of-Pocket Limit (Single/Family)	$3,000/$6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$35/$35
o allergy injections (PCP and SCP)	No copayment/coinsurance (if billed with OV copay, then copay applies.)
o allergy testing	No copayment/coinsurance (if billed with OV copay, then copay applies.)
o routine and non-routine mammograms (regardless of outpatient setting)	$35
o diabetic education (regardless of outpatient setting)	$35
o certain medical nutritional therapy (regardless of outpatient setting)	$35
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Vision and Hearing screenings	
o Physician Home and Office Visits (PCP/SCP)	$35
o Other Outpatient Services @ Hospital/Alternative Care Facility	$150
Emergency and Urgent Care **Emergency Room Services**	$100
o **facility/other covered services** (copayment waived if admitted)	
Urgent Care Center Services	$50
o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies,	
o Allergy injections	
o Allergy testing	
Inpatient and Outpatient Professional Services Include but are not limited to:	No copayment/coinsurance
o Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	
Blue 3.0	

Your Summary of Benefits

Covered Benefits	Network
Inpatient Facility Services Unlimited days except for: o Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) o Unlimited days for skilled nursing facility	$500
Outpatient Surgery Hospital/Alternative Care Facility o Surgery and administration of general anesthesia	$250
Other Outpatient Services including but not limited to: o Non-Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. o Home Care Services Unlimited (excludes IV Therapy) o Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, limbs and Medical Supplies) o Prosthetic Devices o Prosthetic Limbs o Physical Medicine Therapy Day Rehabilitation programs o Hospice Care o Ambulance Services	$150 20% 20% 20% $150 No copayment/coinsurance No copayment/coinsurance
Outpatient Therapy Services (limits apply) o Physician Home and Office Visits (PCP/SCP) o Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: o Physical therapy: 30 visits o Occupational therapy: 30 visits o Manipulation therapy: 12 visits o Speech therapy: 20 visits	 $35/$35 $150
Accidental Dental:	Copayments/Coinsurance based on setting where covered services are received
Behavioral Health Services **Mental Illness and Substance Abuse[2]:** o Inpatient Facility Services o Inpatient Professional Services o Physician Home and Office Visits (PCP/SCP) o Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 $500 No copayment/coinsurance $35/$35 No copayment/coinsurance
Human Organ and Tissue Transplants[3] o Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance

Your Summary of Benefits

Covered Benefits	Network
Prescription Drugs Network[4]	
Tier structure equals 1/2/3 (and 4, if applicable)	
o **Network Retail Pharmacies:** (30-day supply)	$20/$40/$80/$80
Includes diabetic test strip	No copayment/coinsurance
o **Anthem Rx Direct Mail Service:** (90-day supply)	$40/$80/$160/$160
Includes diabetic test strip	No copayment/coinsurance
Member may be responsible for additional cost when not selecting the available generic drug.	**Out of Pocket Limit**
Medicare Rx - Wrap	
Specialty Medications must be obtained via our Specialty Pharmacy network.	
Lifetime Maximum[5]	
Medical	Unlimited
Surgical Treatment of Morbid Obesity	Unlimited

Notes:

- Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health Services where coinsurance applies.
- Dependent age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year
- Prosthetic limbs are unlimited and do not apply to the Plan Lifetime Maximum.
- Mammograms (Routine and Diagnostic), Diabetic Education and Medical Nutritional Therapy are subject to the PCP/OV cost share in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
- Preventive Prescription Drugs that meet the requirements of federal and state law.

1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
2 We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services (Mental Health and Substance Abuse) benefits provided in accordance with Federal Mental Health parity.
3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
4 If applicable: all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail Service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.

Pre-existing Exclusion Period:
We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements and excludes Members under age 19):

12 months after the member's enrollment date

Your Summary of Benefits

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Grandfathered Health Plan

Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross Blue Shield at the telephone number printed on the back of your member identification card, or *contact your group benefits administrator if you do not have an identification card.* For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Your Anthem Benefits

Anthem

MSD of Wayne Township
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2011

Please Note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)	
Deductible (Single/Family) *(Applies only to percent (%) copayments)*	$500/$1,000 Network/$1,000/$2,000 Non-network	
Out-of-Pocket Maximum (Single/Family)	$2,000/$4,000 Network/$4,000/$8,000 Non-network	
Office Services • Including Allergy – testing and treatment – serum and injections[1]	$35 Network/40% Non-network Per Visit	
Preventive Care	$35 Network/40% Non-network Per Visit. Included with no age or dollar limits; Non-network benefits apply. Preventive care includes: medical history, mammograms[1], pelvic exams and Pap tests, immunizations[1], routine and annual diabetic eye exams and hearing exams.	
Maternity Services	20% Network/40% Non-network	
Inpatient Services	20% Network/40% Non-network per admission	
Outpatient Facility Services	20% Network/40% Non-network	
Professional/Home Care (Inpatient/Outpatient)	20% Network/40% Non-network	
Emergency and Urgent Care:		
Emergency Care in ER Room *(covers all services, waived if admitted)*	$150 Network or Non-network	
Urgent Care Facility	$50 Network or Non-network	
Hospice/Ambulance	Covered in full Network or Non-network	
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network	
Outpatient Therapy Visit Limits *(Limits apply to Network/Non-network combined visits.)*		
Physical/Occupational	60 Network and Non-network combined visits; same copay as office services	
Spinal Manipulation	12 Network and Non-network combined visits; same copay as office services	
Speech	20 Network and Non-network combined visits; same copay as office services	
Mental Health and Substance Abuse[2]	Covered as any other illness. Subject to same copays, deductibles and maximums.	
Lifetime Maximum	UNLIMITED	
Human Organ and Tissue Transplants[3]	Covered in full Network/50% Non-network (Does not count toward out-of-pocket maximum)	
Prescription Drug Options:	**Network**	**Non-network**
Network Retail Pharmacies: (30-day supply)	$20 formulary generic/$40 formulary brand $80 non-formulary generic/brand	50% Non-network
Anthem Rx Direct Mail Service: (90-day supply)	$40 formulary generic/$80 formulary brand $160 non-formulary generic/brand	Not covered Non-network

Notes:

- *The deductibles and copayments (except prescription drug and human organ and tissue transplants, excluding kidney and cornea) apply toward the out-of-pocket maximums.*
- *The deductible(s) apply only to covered services listed with a percentage (%) copayment.*
- *Network and Non-network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent age: to the end of the month which the child attains age 26.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies.*
- *Office services also includes office surgeries and preconception care/education.*

1 *These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.*

2 *We encourage you to contact our Mental Health Subcontractor to assure the use of appropriate procedures, settings and Medical Necessity. Refer to the Schedule of Benefits for limitations.*

3 *Human organ and tissue transplants (except kidney and cornea) are covered in full Network; 50% Non-network. Does not count toward the out-of-pocket maximum.*
Kidney and cornea are covered same as any other illness.

4 *If applicable, all prescription drug expenses (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.*

Precertification:

Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period:
We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements and excludes Members under age 19):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Grandfathered Health Plan
We believe this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the plan administrator or your Employer.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Benefit information contained herein is not final, pending approval of the Indiana Dept. of Insurance.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Your Summary of Benefits

Anthem.

MSD of Wayne Township
Blue Access® for Health Savings Accounts Option H06 % Rx
Effective January 1, 2011

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Physician Home and Office Services o Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams o Physician Home and Office Visits o Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	30%
Emergency and Urgent Care o **Emergency Room Services (facility/other covered services)** (copayment waived if admitted) o **Urgent Care Center Services**	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: o Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: o 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) o 90 days for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility o Surgery and administration of general anesthesia	0%	30%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Other Outpatient Services (Network/Non-network combined) including but not limited to: o Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. o Home Care Services 90 visits (excludes IV Therapy) o Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, Limbs and Medical Supplies) o Prosthetic Devices o Prosthetic Limbs o Physical Medicine Therapy Day Rehabilitation programs o Hospice Care o Ambulance Services	0% 0% 0%	30% 0% 0%
Accidental Dental Services Unlimited	0%	30%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) o Physician Home and Office Visits o Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: o Physical therapy: 20 visits o Occupational therapy: 20 visits o Manipulation therapy: 12 visits o Speech therapy: 20 visits	 0% 0%	 30% 30%
Behavioral Health Service **Mental Illness and Substance Abuse[1]:** o Inpatient Facility Services o Inpatient Professional Services o Physician Home and Office Visits (PCP/SCP) o Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional.	0%	30%
Human Organ and Tissue Transplants o Acquisition and transplant procedures, harvest and storage.	0%	30%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Prescription Drugs o **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip o **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Medicare Rx <SELECT>	0% 0%	30%[2] Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.
- Network and non-network deductibles, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the month in which the child attains age 26.
- 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit period = calendar year
- Prosthetics Limbs are unlimited.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
- Preventive Prescription Drugs that meet the requirements of federal and state law.

1 We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services (Mental Health and Substance Abuse) benefits provided in accordance with Federal Mental Health Parity.
2 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
3 Meets Indiana state mandate effective 7/1/08.

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period:
We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements excludes Members under age 19):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Grandfathered Health Plan

Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross Blue Shield at the telephone number printed

on the back of your member identification card, or *contact your group benefits administrator if you do not have an identification card.* For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Your Anthem Benefits

Anthem

MSD of Wayne Township
Blue Access℠ (PPO)
Summary of Benefits, Effective January 1, 2012

Please Note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)	
Deductible (Single/Family) *(Applies only to percent (%) copayments)*	$500/$1,000 Network/$1,000/$2,000 Non-network	
Out-of-Pocket Maximum (Single/Family)	$2,000/$4,000 Network/$4,000/$8,000 Non-network	
Office Services • Including Allergy – testing and treatment – serum and injections[1]	$35 Network/40% Non-network Per Visit	
Preventive Care	$35 Network/40% Non-network Per Visit. Included with no age or dollar limits; Non-network benefits apply. Preventive care includes: medical history, mammograms[1], pelvic exams and Pap tests, immunizations[1], routine and annual diabetic eye exams and hearing exams.	
Maternity Services	20% Network/40% Non-network	
Inpatient Services	20% Network/40% Non-network per admission	
Outpatient Facility Services	20% Network/40% Non-network	
Professional/Home Care (Inpatient/Outpatient)	20% Network/40% Non-network	
Emergency and Urgent Care:		
Emergency Care in ER Room *(covers all services, waived if admitted)*	$150 Network or Non-network	
Urgent Care Facility	$50 Network or Non-network	
Hospice/Ambulance	Covered in full Network or Non-network	
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network	
Outpatient Therapy Visit Limits *(Limits apply to Network/Non-network combined visits.)*		
Physical/Occupational	60 Network and Non-network combined visits; same copay as office services	
Spinal Manipulation	12 Network and Non-network combined visits; same copay as office services	
Speech	20 Network and Non-network combined visits; same copay as office services	
Mental Health and Substance Abuse[2]		
• Inpatient Facility Services	20% Network/40% Non-network	
• Inpatient Professional Services	20% Network/40% Non-network	
• Physician Home and Office Visits (PCP/SCP)	$35 Network/40% Non-network	
• Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	20% Network/40% Non-network	
Lifetime Maximum	UNLIMITED	
Human Organ and Tissue Transplants[3]	Covered in full Network/50% Non-network (Does not count toward out-of-pocket maximum)	
Prescription Drug Options:	**Network**	**Non-network**
Network Retail Pharmacies: (30-day supply)	$20 formulary generic/$40 formulary brand $80 non-formulary generic/brand	50% Non-network
Anthem Rx Direct Mail Service: (90-day supply)	$40 formulary generic/$80 formulary brand $160 non-formulary generic/brand	Not covered Non-network

Your Summary of Benefits

Anthem.

MSD of Wayne Township
Blue Access® for Health Savings Accounts Option H06 % Rx
Effective January 1, 2012

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit	Single: $2,000 Family: $4,000	Single: $8,000 Family: $16,000
Physician Home and Office Services o Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams o Physician Home and Office Visits o Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	30%
Emergency and Urgent Care o **Emergency Room Services (facility/other covered services)** (copayment waived if admitted) o **Urgent Care Center Services**	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: o Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: o 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) o 90 days for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility o Surgery and administration of general anesthesia	0%	30%
Blue 3.0		

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Prescription Drugs • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Medicare Rx <SELECT>	0% 0%	30%[2] Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.
- Network and non-network deductibles, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the month in which the child attains age 26.
- 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit period = calendar year
- Prosthetics Limbs are unlimited.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
- Preventive Prescription Drugs that meet the requirements of federal and state law.

1 We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services (Mental Health and Substance Abuse) benefits provided in accordance with Federal Mental Health Parity.
2 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
3 Meets Indiana state mandate effective 7/1/08.

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-existing Exclusion Period:
We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements excludes Members under age 19):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Grandfathered Health Plan
Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross Blue Shield at the telephone number printed

Your Summary of Benefits

Anthem.

MSD of Wayne Township
Blue Preferred® (HMO)
Effective January 1, 2012

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits

Covered Benefits	Network
Deductible (Single/Family)	$250/$500
Out-of-Pocket Limit (Single/Family)	$3,000/$6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • routine and non-routine mammograms (regardless of outpatient setting) • diabetic education (regardless of outpatient setting) • certain medical nutritional therapy (regardless of outpatient setting)	$35/$35 No copayment/coinsurance (if billed with OV copay, then copay applies.) No copayment/coinsurance (if billed with OV copay, then copay applies.) $35 $35 $35
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Vision and Hearing screenings • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 $35 $150
Emergency and Urgent Care Emergency Room Services • facility/other covered services (copayment waived if admitted) Urgent Care Center Services • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, • Allergy injections • Allergy testing	 $100 $50
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	No copayment/coinsurance
Blue 3.0	

Your Summary of Benefits

Covered Benefits	Network
Inpatient Facility Services Unlimited days except for: • Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • Unlimited days for skilled nursing facility	$500
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	$250
Other Outpatient Services including but not limited to: • Non-Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services Unlimited (excludes IV Therapy) • Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, limbs and Medical Supplies) • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	$150 20% 20% 20% $150 No copayment/coinsurance No copayment/coinsurance
Outpatient Therapy Services (limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical/Occupational therapy: 60 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits	 $35/$35 $150
Accidental Dental:	Copayments/Coinsurance based on setting where covered services are received
Behavioral Health Services **Mental Illness and Substance Abuse[2]:** • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 $500 No copayment/coinsurance $35/$35 No copayment/coinsurance
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance

Your Summary of Benefits

Covered Benefits	Network
Prescription Drugs Network[4]	
Tier structure equals 1/2/3 (and 4, if applicable)	
• **Network Retail Pharmacies:** (30-day supply)	$20/$40/$80/$80
Includes diabetic test strip	No copayment/coinsurance
• **Anthem Rx Direct Mail Service:** (90-day supply)	$40/$80/$160/$160
Includes diabetic test strip	No copayment/coinsurance
Member may be responsible for additional cost when not selecting the available generic drug.	**Out of Pocket Limit**
Medicare Rx - Wrap	
Specialty Medications must be obtained via our Specialty Pharmacy network.	
Lifetime Maximum[5]	
Medical	Unlimited
Surgical Treatment of Morbid Obesity	Unlimited

Notes:

- Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health Services where coinsurance applies.
- Dependent age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies include diabetic test strips.
- Benefit period = calendar year
- Prosthetic limbs are unlimited and do not apply to the Plan Lifetime Maximum.
- Mammograms (Routine and Diagnostic), Diabetic Education and Medical Nutritional Therapy are subject to the PCP/OV cost share in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
- Preventive Prescription Drugs that meet the requirements of federal and state law.

1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
2 We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services (Mental Health and Substance Abuse) benefits provided in accordance with Federal Mental Health parity.
3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
4 If applicable: all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail Service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.

Pre-existing Exclusion Period:
We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements and excludes Members under age 19):

12 months after the member's enrollment date

Your Summary of Benefits

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Grandfathered Health Plan

Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross Blue Shield at the telephone number printed on the back of your member identification card, or *contact your group benefits administrator if you do not have an identification card.* For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Benefit information contained herein is not final, pending approval by the Indiana Department of Insurance

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Your Summary of Benefits

Anthem.

MSD of Wayne Township
Blue Access® for Health Savings Accounts Option H06 % Rx
Effective January 1, 2012

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit	Single: $2,000 Family: $4,000	Single: $8,000 Family: $16,000
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	30%
Emergency and Urgent Care • Emergency Room Services (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
Blue 3.0		

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Other Outpatient Services (Network/Non-network combined) including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, Limbs and Medical Supplies) • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%
Accidental Dental Services Unlimited	0%	30%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits	 0% 0%	 30% 30%
Behavioral Health Service **Mental Illness and Substance Abuse**[1]: • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional.	0%	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Prescription Drugs • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Medicare Rx <SELECT>	0% 0%	30%[2] Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.
- Network and non-network deductibles, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the month in which the child attains age 26.
- 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Benefit period = calendar year
- Prosthetics Limbs are unlimited.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
- Preventive Prescription Drugs that meet the requirements of federal and state law.

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Your Summary of Benefits

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This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Benefit information contained herein is not final, pending approval by the Indiana Department of Insurance
By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Anthem Rates by Position
January 1, 2007

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	385.24	192.62	0.04
		Empl + Child	1,001.87	1,001.79	500.90	0.04
		Empl + Spouse	1,051.93	1,051.85	525.93	0.04
		Family	1,413.98	1,413.90	706.95	0.04
	PPO	Single	438.64	438.56	219.28	0.04
		Empl + Child	1,140.40	1,140.32	570.16	0.04
		Empl + Spouse	1,196.99	1,196.91	598.46	0.04
		Family	1,609.68	1,609.60	804.80	0.04
	HSA	Single	374.34	374.26	187.13	0.04
		Empl + Child	973.22	973.14	486.57	0.04
		Empl + Spouse	1021.52	1,021.44	510.72	0.04
		Family	1,373.71	1,373.63	686.82	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	269.31	134.66	58.01
		Empl + Child	1,001.87	573.44	286.72	214.22
		Empl + Spouse	1,051.93	596.13	298.07	227.90
		Family	1,413.98	776.35	388.18	318.82
	PPO	Single	438.64	269.31	134.66	84.67
		Empl + Child	1,140.40	573.44	286.72	283.48
		Empl + Spouse	1,196.99	596.13	298.07	300.43
		Family	1,609.68	776.35	388.18	416.67
	HSA	Single	374.34	269.31	134.66	52.52
		Empl + Child	973.22	573.44	286.72	199.89
		Empl + Spouse	1021.52	596.13	298.07	212.70
		Family	1,373.71	776.35	388.18	298.68

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	134.66	67.33	125.33
		Empl + Child	1,001.87	286.72	143.36	357.58
		Empl + Spouse	1,051.93	298.07	149.03	376.93
		Family	1,413.98	388.18	194.09	512.90
	PPO	Single	438.64	134.66	67.33	151.99
		Empl + Child	1,140.40	286.72	143.36	426.84
		Empl + Spouse	1,196.99	298.07	149.03	449.46
		Family	1,609.68	388.18	194.09	610.75
	HSA	Single	374.34	134.66	67.33	119.84
		Empl + Child	973.22	286.72	143.36	343.25
		Empl + Spouse	1021.52	298.07	149.03	361.73
		Family	1,373.71	388.18	194.09	492.77

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,051.93	789.80	394.90	131.07
		Family	1,413.98	958.59	479.30	227.70
	PPO	Empl + Spouse	1,196.99	789.80	394.90	203.60
		Family	1,609.68	958.59	479.30	325.55
	HSA	Empl + Spouse	1021.52	789.80	394.90	115.86
		Family	1,373.71	958.59	479.30	207.56

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	462.38	367.20	183.60	47.59
		Empl + Child	1,202.24	488.40	244.20	356.92
		Empl + Spouse	1,262.32	488.40	244.20	386.96
		Family	1,696.78	488.40	244.20	604.19
	PPO	Single	526.37	367.20	183.60	79.58
		Empl + Child	1,368.48	488.40	244.20	440.04
		Empl + Spouse	1,436.39	488.40	244.20	473.99
		Family	1,931.62	488.40	244.20	721.61
	HSA	Single	449.21	367.20	183.60	41.00
		Empl + Child	1,167.86	488.40	244.20	339.73
		Empl + Spouse	1,225.82	488.40	244.20	368.71
		Family	1,648.45	488.40	244.20	580.03

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	462.38	367.20	183.60	47.59
		Empl + Child	1,202.24	488.40	244.20	356.92
		Empl + Spouse	1,262.32	488.40	244.20	386.96
		Family	1,696.78	488.40	244.20	604.19
	PPO	Single	526.37	367.20	183.60	79.58
		Empl + Child	1,368.48	488.40	244.20	440.04
		Empl + Spouse	1,436.39	488.40	244.20	473.99
		Family	1,931.62	488.40	244.20	721.61
	HSA	Single	449.21	367.20	183.60	41.00
		Empl + Child	1,167.86	488.40	244.20	339.73
		Empl + Spouse	1,225.82	488.40	244.20	368.71
		Family	1,648.45	488.40	244.20	580.03

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	306.00	153.00	39.66
		Empl + Child	1,001.87	495.00	247.50	253.44
		Empl + Spouse	1,051.93	495.00	247.50	278.47
		Family	1,413.98	542.00	271.00	435.99
	PPO	Single	438.64	306.00	153.00	66.32
		Empl + Child	1,140.40	495.00	247.50	322.70
		Empl + Spouse	1,196.99	495.00	247.50	351.00
		Family	1,609.68	542.00	271.00	533.84
	HSA	Single	374.34	306.00	153.00	34.17
		Empl + Child	973.22	495.00	247.50	239.11
		Empl + Spouse	1021.52	495.00	247.50	263.26
		Family	1,373.71	542.00	271.00	415.86

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer	HMO	Single	385.32	306.00	153.00	39.66
		Empl + Child	1,001.87	495.00	247.50	253.44
		Empl + Spouse	1,051.93	495.00	247.50	278.47
		Family	1,413.98	542.00	271.00	435.99
	PPO	Single	438.64	306.00	153.00	66.32
		Empl + Child	1,140.40	495.00	247.50	322.70
		Empl + Spouse	1,196.99	495.00	247.50	351.00
		Family	1,609.68	542.00	271.00	533.84
	HSA	Single	374.34	306.00	153.00	34.17
		Empl + Child	973.22	495.00	247.50	239.11
		Empl + Spouse	1021.52	495.00	247.50	263.26
		Family	1,373.71	542.00	271.00	415.86

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	306.00	153.00	39.66
		Empl + Child	1,001.87	407.00	203.50	297.44
		Empl + Spouse	1,051.93	407.00	203.50	322.47
		Family	1,413.98	407.00	203.50	503.49
	PPO	Single	438.64	306.00	153.00	66.32
		Empl + Child	1,140.40	407.00	203.50	366.70
		Empl + Spouse	1,196.99	407.00	203.50	395.00
		Family	1,609.68	407.00	203.50	601.34
	HSA	Single	374.34	306.00	153.00	34.17
		Empl + Child	973.22	407.00	203.50	283.11
		Empl + Spouse	1021.52	407.00	203.50	307.26
		Family	1,373.71	407.00	203.50	483.36

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	308.00	154.00	38.66
		Empl + Child	1,001.87	368.00	184.00	316.94
		Empl + Spouse	1,051.93	368.00	184.00	341.97
		Family	1,413.98	368.00	184.00	522.99
	PPO	Single	438.64	308.00	154.00	65.32
		Empl + Child	1,140.40	368.00	184.00	386.20
		Empl + Spouse	1,196.99	368.00	184.00	414.50
		Family	1,609.68	368.00	184.00	620.84
	HSA	Single	374.34	308.00	154.00	33.17
		Empl + Child	973.22	368.00	184.00	302.61
		Empl + Spouse	1021.52	368.00	184.00	326.76
		Family	1,373.71	368.00	184.00	502.86

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	268.00	134.00	58.66
		Empl + Child	1,001.87	336.00	168.00	332.94
		Empl + Spouse	1,051.93	336.00	168.00	357.97
		Family	1,413.98	336.00	168.00	538.99
	PPO	Single	438.64	268.00	134.00	85.32
		Empl + Child	1,140.40	336.00	168.00	402.20
		Empl + Spouse	1,196.99	336.00	168.00	430.50
		Family	1,609.68	336.00	168.00	636.84
	HSA	Single	374.34	268.00	134.00	53.17
		Empl + Child	973.22	336.00	168.00	318.61
		Empl + Spouse	1021.52	336.00	168.00	342.76
		Family	1,373.71	336.00	168.00	518.86

Service Manager/ Special Ed Transportation Mgr	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	306.00	153.00	39.66
		Empl + Child	1,001.87	793.00	396.50	104.44
		Empl + Spouse	1,051.93	793.00	396.50	129.47
		Family	1,413.98	1,058.00	529.00	177.99
	PPO	Single	438.64	306.00	153.00	66.32
		Empl + Child	1,140.40	793.00	396.50	173.70
		Empl + Spouse	1,196.99	793.00	396.50	202.00
		Family	1,609.68	1,058.00	529.00	275.84
	HSA	Single	374.34	306.00	153.00	34.17
		Empl + Child	973.22	793.00	396.50	90.11
		Empl + Spouse	1021.52	793.00	396.50	114.26
		Family	1,373.71	1,058.00	529.00	157.86

Anthem Rates by Position
July 15, 2007

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	385.24	192.62	0.04
		Empl + Child	1,001.87	1,001.79	500.90	0.04
		Empl + Spouse	1,051.93	1,051.85	525.93	0.04
		Family	1,413.98	1,413.90	706.95	0.04
	PPO	Single	438.64	438.56	219.28	0.04
		Empl + Child	1,140.40	1,140.32	570.16	0.04
		Empl + Spouse	1,196.99	1,196.91	598.46	0.04
		Family	1,609.68	1,609.60	804.80	0.04
	HSA	Single	374.34	374.26	187.13	0.04
		Empl + Child	973.22	973.14	486.57	0.04
		Empl + Spouse	1021.52	1,021.44	510.72	0.04
		Family	1,373.71	1,373.63	686.82	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	269.31	134.66	58.01
		Empl + Child	1,001.87	573.44	286.72	214.22
		Empl + Spouse	1,051.93	596.13	298.07	227.90
		Family	1,413.98	776.35	388.18	318.82
	PPO	Single	438.64	269.31	134.66	84.67
		Empl + Child	1,140.40	573.44	286.72	283.48
		Empl + Spouse	1,196.99	596.13	298.07	300.43
		Family	1,609.68	776.35	388.18	416.67
	HSA	Single	374.34	269.31	134.66	52.52
		Empl + Child	973.22	573.44	286.72	199.89
		Empl + Spouse	1021.52	596.13	298.07	212.70
		Family	1,373.71	776.35	388.18	298.68

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	134.66	67.33	125.33
		Empl + Child	1,001.87	286.72	143.36	357.58
		Empl + Spouse	1,051.93	298.07	149.03	376.93
		Family	1,413.98	388.18	194.09	512.90
	PPO	Single	438.64	134.66	67.33	151.99
		Empl + Child	1,140.40	286.72	143.36	426.84
		Empl + Spouse	1,196.99	298.07	149.03	449.46
		Family	1,609.68	388.18	194.09	610.75
	HSA	Single	374.34	134.66	67.33	119.84
		Empl + Child	973.22	286.72	143.36	343.25
		Empl + Spouse	1021.52	298.07	149.03	361.73
		Family	1,373.71	388.18	194.09	492.77

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,051.93	789.80	394.90	131.07
		Family	1,413.98	958.59	479.30	227.70
	PPO	Empl + Spouse	1,196.99	789.80	394.90	203.60
		Family	1,609.68	958.59	479.30	325.55
	HSA	Empl + Spouse	1021.52	789.80	394.90	115.86
		Family	1,373.71	958.59	479.30	207.56

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	462.38	367.20	183.60	47.59
		Empl + Child	1,202.24	488.40	244.20	356.92
		Empl + Spouse	1,262.32	488.40	244.20	386.96
		Family	1,696.78	488.40	244.20	604.19
	PPO	Single	526.37	367.20	183.60	79.58
		Empl + Child	1,368.48	488.40	244.20	440.04
		Empl + Spouse	1,436.39	488.40	244.20	473.99
		Family	1,931.62	488.40	244.20	721.61
	HSA	Single	449.21	367.20	183.60	41.00
		Empl + Child	1,167.86	488.40	244.20	339.73
		Empl + Spouse	1,225.82	488.40	244.20	368.71
		Family	1,648.45	488.40	244.20	580.03

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	462.38	367.20	183.60	47.59
		Empl + Child	1,202.24	488.40	244.20	356.92
		Empl + Spouse	1,262.32	488.40	244.20	386.96
		Family	1,696.78	488.40	244.20	604.19
	PPO	Single	526.37	367.20	183.60	79.58
		Empl + Child	1,368.48	488.40	244.20	440.04
		Empl + Spouse	1,436.39	488.40	244.20	473.99
		Family	1,931.62	488.40	244.20	721.61
	HSA	Single	449.21	367.20	183.60	41.00
		Empl + Child	1,167.86	488.40	244.20	339.73
		Empl + Spouse	1,225.82	488.40	244.20	368.71
		Family	1,648.45	488.40	244.20	580.03

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	327.00	163.50	29.16
		Empl + Child	1,001.87	530.00	265.00	235.94
		Empl + Spouse	1,051.93	530.00	265.00	260.97
		Family	1,413.98	580.00	290.00	416.99
	PPO	Single	438.64	327.00	163.50	55.82
		Empl + Child	1,140.40	530.00	265.00	305.20
		Empl + Spouse	1,196.99	530.00	265.00	333.50
		Family	1,609.68	580.00	290.00	514.84
	HSA	Single	374.34	327.00	163.50	23.67
		Empl + Child	973.22	530.00	265.00	221.61
		Empl + Spouse	1021.52	530.00	265.00	245.76
		Family	1,373.71	580.00	290.00	396.86

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer	HMO	Single	385.32	327.00	163.50	29.16
		Empl + Child	1,001.87	530.00	265.00	235.94
		Empl + Spouse	1,051.93	530.00	265.00	260.97
		Family	1,413.98	580.00	290.00	416.99
	PPO	Single	438.64	327.00	163.50	55.82
		Empl + Child	1,140.40	530.00	265.00	305.20
		Empl + Spouse	1,196.99	530.00	265.00	333.50
		Family	1,609.68	580.00	290.00	514.84
	HSA	Single	374.34	327.00	163.50	23.67
		Empl + Child	973.22	530.00	265.00	221.61
		Empl + Spouse	1021.52	530.00	265.00	245.76
		Family	1,373.71	580.00	290.00	396.86

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	327.00	163.50	29.16
		Empl + Child	1,001.87	435.00	217.50	283.44
		Empl + Spouse	1,051.93	435.00	217.50	308.47
		Family	1,413.98	435.00	217.50	489.49
	PPO	Single	438.64	327.00	163.50	55.82
		Empl + Child	1,140.40	435.00	217.50	352.70
		Empl + Spouse	1,196.99	435.00	217.50	381.00
		Family	1,609.68	435.00	217.50	587.34
	HSA	Single	374.34	327.00	163.50	23.67
		Empl + Child	973.22	435.00	217.50	269.11
		Empl + Spouse	1021.52	435.00	217.50	293.26
		Family	1,373.71	435.00	217.50	469.36

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	308.00	154.00	38.66
		Empl + Child	1,001.87	368.00	184.00	316.94
		Empl + Spouse	1,051.93	368.00	184.00	341.97
		Family	1,413.98	368.00	184.00	522.99
	PPO	Single	438.64	308.00	154.00	65.32
		Empl + Child	1,140.40	368.00	184.00	386.20
		Empl + Spouse	1,196.99	368.00	184.00	414.50
		Family	1,609.68	368.00	184.00	620.84
	HSA	Single	374.34	308.00	154.00	33.17
		Empl + Child	973.22	368.00	184.00	302.61
		Empl + Spouse	1021.52	368.00	184.00	326.76
		Family	1,373.71	368.00	184.00	502.86

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	268.00	134.00	58.66
		Empl + Child	1,001.87	336.00	168.00	332.94
		Empl + Spouse	1,051.93	336.00	168.00	357.97
		Family	1,413.98	336.00	168.00	538.99
	PPO	Single	438.64	268.00	134.00	85.32
		Empl + Child	1,140.40	336.00	168.00	402.20
		Empl + Spouse	1,196.99	336.00	168.00	430.50
		Family	1,609.68	336.00	168.00	636.84
	HSA	Single	374.34	268.00	134.00	53.17
		Empl + Child	973.22	336.00	168.00	318.61
		Empl + Spouse	1021.52	336.00	168.00	342.76
		Family	1,373.71	336.00	168.00	518.86

Service Manager/ Special Ed Transportation Mgr	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	327.00	163.50	29.16
		Empl + Child	1,001.87	530.00	265.00	235.94
		Empl + Spouse	1,051.93	530.00	265.00	260.97
		Family	1,413.98	580.00	290.00	416.99
	PPO	Single	438.64	327.00	163.50	55.82
		Empl + Child	1,140.40	530.00	265.00	305.20
		Empl + Spouse	1,196.99	530.00	265.00	333.50
		Family	1,609.68	580.00	290.00	514.84
	HSA	Single	374.34	327.00	163.50	23.67
		Empl + Child	973.22	530.00	265.00	221.61
		Empl + Spouse	1021.52	530.00	265.00	245.76
		Family	1,373.71	580.00	290.00	396.86

Anthem Rates by Position
September 1, 2007

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	385.24	192.62	0.04
		Empl + Child	1,001.87	1,001.79	500.90	0.04
		Empl + Spouse	1,051.93	1,051.85	525.93	0.04
		Family	1,413.98	1,413.90	706.95	0.04
	PPO	Single	438.64	438.56	219.28	0.04
		Empl + Child	1,140.40	1,140.32	570.16	0.04
		Empl + Spouse	1,196.99	1,196.91	598.46	0.04
		Family	1,609.68	1,609.60	804.80	0.04
	HSA	Single	374.34	374.26	187.13	0.04
		Empl + Child	973.22	973.14	486.57	0.04
		Empl + Spouse	1021.52	1,021.44	510.72	0.04
		Family	1,373.71	1,373.63	686.82	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	269.31	134.66	58.01
		Empl + Child	1,001.87	573.44	286.72	214.22
		Empl + Spouse	1,051.93	596.13	298.07	227.90
		Family	1,413.98	776.35	388.18	318.82
	PPO	Single	438.64	269.31	134.66	84.67
		Empl + Child	1,140.40	573.44	286.72	283.48
		Empl + Spouse	1,196.99	596.13	298.07	300.43
		Family	1,609.68	776.35	388.18	416.67
	HSA	Single	374.34	269.31	134.66	52.52
		Empl + Child	973.22	573.44	286.72	199.89
		Empl + Spouse	1021.52	596.13	298.07	212.70
		Family	1,373.71	776.35	388.18	298.68

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	134.66	67.33	125.33
		Empl + Child	1,001.87	286.72	143.36	357.58
		Empl + Spouse	1,051.93	298.07	149.03	376.93
		Family	1,413.98	388.18	194.09	512.90
	PPO	Single	438.64	134.66	67.33	151.99
		Empl + Child	1,140.40	286.72	143.36	426.84
		Empl + Spouse	1,196.99	298.07	149.03	449.46
		Family	1,609.68	388.18	194.09	610.75
	HSA	Single	374.34	134.66	67.33	119.84
		Empl + Child	973.22	286.72	143.36	343.25
		Empl + Spouse	1021.52	298.07	149.03	361.73
		Family	1,373.71	388.18	194.09	492.77

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,051.93	789.80	394.90	131.07
		Family	1,413.98	958.59	479.30	227.70
	PPO	Empl + Spouse	1,196.99	789.80	394.90	203.60
		Family	1,609.68	958.59	479.30	325.55
	HSA	Empl + Spouse	1021.52	789.80	394.90	115.86
		Family	1,373.71	958.59	479.30	207.56

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	462.38	367.20	183.60	47.59
		Empl + Child	1,202.24	488.40	244.20	356.92
		Empl + Spouse	1,262.32	488.40	244.20	386.96
		Family	1,696.78	488.40	244.20	604.19
	PPO	Single	526.37	367.20	183.60	79.58
		Empl + Child	1,368.48	488.40	244.20	440.04
		Empl + Spouse	1,436.39	488.40	244.20	473.99
		Family	1,931.62	488.40	244.20	721.61
	HSA	Single	449.21	367.20	183.60	41.00
		Empl + Child	1,167.86	488.40	244.20	339.73
		Empl + Spouse	1,225.82	488.40	244.20	368.71
		Family	1,648.45	488.40	244.20	580.03

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	462.38	367.20	183.60	47.59
		Empl + Child	1,202.24	488.40	244.20	356.92
		Empl + Spouse	1,262.32	488.40	244.20	386.96
		Family	1,696.78	488.40	244.20	604.19
	PPO	Single	526.37	367.20	183.60	79.58
		Empl + Child	1,368.48	488.40	244.20	440.04
		Empl + Spouse	1,436.39	488.40	244.20	473.99
		Family	1,931.62	488.40	244.20	721.61
	HSA	Single	449.21	367.20	183.60	41.00
		Empl + Child	1,167.86	488.40	244.20	339.73
		Empl + Spouse	1,225.82	488.40	244.20	368.71
		Family	1,648.45	488.40	244.20	580.03

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	327.00	163.50	29.16
		Empl + Child	1,001.87	530.00	265.00	235.94
		Empl + Spouse	1,051.93	530.00	265.00	260.97
		Family	1,413.98	580.00	290.00	416.99
	PPO	Single	438.64	327.00	163.50	55.82
		Empl + Child	1,140.40	530.00	265.00	305.20
		Empl + Spouse	1,196.99	530.00	265.00	333.50
		Family	1,609.68	580.00	290.00	514.84
	HSA	Single	374.34	327.00	163.50	23.67
		Empl + Child	973.22	530.00	265.00	221.61
		Empl + Spouse	1021.52	530.00	265.00	245.76
		Family	1,373.71	580.00	290.00	396.86

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer	HMO	Single	385.32	327.00	163.50	29.16
		Empl + Child	1,001.87	530.00	265.00	235.94
		Empl + Spouse	1,051.93	530.00	265.00	260.97
		Family	1,413.98	580.00	290.00	416.99
	PPO	Single	438.64	327.00	163.50	55.82
		Empl + Child	1,140.40	530.00	265.00	305.20
		Empl + Spouse	1,196.99	530.00	265.00	333.50
		Family	1,609.68	580.00	290.00	514.84
	HSA	Single	374.34	327.00	163.50	23.67
		Empl + Child	973.22	530.00	265.00	221.61
		Empl + Spouse	1021.52	530.00	265.00	245.76
		Family	1,373.71	580.00	290.00	396.86

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	327.00	163.50	29.16
		Empl + Child	1,001.87	435.00	217.50	283.44
		Empl + Spouse	1,051.93	435.00	217.50	308.47
		Family	1,413.98	435.00	217.50	489.49
	PPO	Single	438.64	327.00	163.50	55.82
		Empl + Child	1,140.40	435.00	217.50	352.70
		Empl + Spouse	1,196.99	435.00	217.50	381.00
		Family	1,609.68	435.00	217.50	587.34
	HSA	Single	374.34	327.00	163.50	23.67
		Empl + Child	973.22	435.00	217.50	269.11
		Empl + Spouse	1021.52	435.00	217.50	293.26
		Family	1,373.71	435.00	217.50	469.36

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	330.00	165.00	27.66
		Empl + Child	1,001.87	394.00	197.00	303.94
		Empl + Spouse	1,051.93	394.00	197.00	328.97
		Family	1,413.98	394.00	197.00	509.99
	PPO	Single	438.64	330.00	165.00	54.32
		Empl + Child	1,140.40	394.00	197.00	373.20
		Empl + Spouse	1,196.99	394.00	197.00	401.50
		Family	1,609.68	394.00	197.00	607.84
	HSA	Single	374.34	330.00	165.00	22.17
		Empl + Child	973.22	394.00	197.00	289.61
		Empl + Spouse	1021.52	394.00	197.00	313.76
		Family	1,373.71	394.00	197.00	489.86

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	287.00	143.50	49.16
		Empl + Child	1,001.87	360.00	180.00	320.94
		Empl + Spouse	1,051.93	360.00	180.00	345.97
		Family	1,413.98	360.00	180.00	526.99
	PPO	Single	438.64	287.00	143.50	75.82
		Empl + Child	1,140.40	360.00	180.00	390.20
		Empl + Spouse	1,196.99	360.00	180.00	418.50
		Family	1,609.68	360.00	180.00	624.84
	HSA	Single	374.34	287.00	143.50	43.67
		Empl + Child	973.22	360.00	180.00	306.61
		Empl + Spouse	1021.52	360.00	180.00	330.76
		Family	1,373.71	360.00	180.00	506.86

Service Manager/ Special Ed Transportation Mgr	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	327.00	163.50	29.16
		Empl + Child	1,001.87	849.00	424.50	76.44
		Empl + Spouse	1,051.93	849.00	424.50	101.47
		Family	1,413.98	1,132.00	566.00	140.99
	PPO	Single	438.64	327.00	163.50	55.82
		Empl + Child	1,140.40	849.00	424.50	145.70
		Empl + Spouse	1,196.99	849.00	424.50	174.00
		Family	1,609.68	1,132.00	566.00	238.84
	HSA	Single	374.34	327.00	163.50	23.67
		Empl + Child	973.22	849.00	424.50	62.11
		Empl + Spouse	1021.52	849.00	424.50	86.26
		Family	1,373.71	1,132.00	566.00	120.86

Anthem Rates by Position
December 15, 2007

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	385.24	192.62	0.04
		Empl + Child	1,001.87	1,001.79	500.90	0.04
		Empl + Spouse	1,051.93	1,051.85	525.93	0.04
		Family	1,413.98	1,413.90	706.95	0.04
	PPO	Single	438.64	438.56	219.28	0.04
		Empl + Child	1,140.40	1,140.32	570.16	0.04
		Empl + Spouse	1,196.99	1,196.91	598.46	0.04
		Family	1,609.68	1,609.60	804.80	0.04
	HSA	Single	374.34	374.26	187.13	0.04
		Empl + Child	973.22	973.14	486.57	0.04
		Empl + Spouse	1021.52	1,021.44	510.72	0.04
		Family	1,373.71	1,373.63	686.82	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	288.16	144.08	48.58
		Empl + Child	1,001.87	613.58	306.79	194.15
		Empl + Spouse	1,051.93	637.86	318.93	207.04
		Family	1,413.98	830.69	415.35	291.65
	PPO	Single	438.64	288.16	144.08	75.24
		Empl + Child	1,140.40	613.58	306.79	263.41
		Empl + Spouse	1,196.99	637.86	318.93	279.57
		Family	1,609.68	830.69	415.35	389.50
	HSA	Single	374.34	288.16	144.08	43.09
		Empl + Child	973.22	613.58	306.79	179.82
		Empl + Spouse	1021.52	637.86	318.93	191.83
		Family	1,373.71	830.69	415.35	271.51

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	144.08	72.04	120.62
		Empl + Child	1,001.87	306.79	153.40	347.54
		Empl + Spouse	1,051.93	318.93	159.47	366.50
		Family	1,413.98	415.35	207.67	499.32
	PPO	Single	438.64	144.08	72.04	147.28
		Empl + Child	1,140.40	306.79	153.40	416.81
		Empl + Spouse	1,196.99	318.93	159.47	439.03
		Family	1,609.68	415.35	207.67	597.17
	HSA	Single	374.34	144.08	72.04	115.13
		Empl + Child	973.22	306.79	153.40	333.22
		Empl + Spouse	1021.52	318.93	159.47	351.30
		Family	1,373.71	415.35	207.67	479.18

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,051.93	845.09	422.55	103.42
		Family	1,413.98	1,025.69	512.85	194.15
	PPO	Empl + Spouse	1,196.99	845.09	422.55	175.95
		Family	1,609.68	1,025.69	512.85	292.00
	HSA	Empl + Spouse	1021.52	845.09	422.55	88.22
		Family	1,373.71	1,025.69	512.85	174.01

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	462.38	367.20	183.60	47.59
		Empl + Child	1,202.24	488.40	244.20	356.92
		Empl + Spouse	1,262.32	488.40	244.20	386.96
		Family	1,696.78	488.40	244.20	604.19
	PPO	Single	526.37	367.20	183.60	79.58
		Empl + Child	1,368.48	488.40	244.20	440.04
		Empl + Spouse	1,436.39	488.40	244.20	473.99
		Family	1,931.62	488.40	244.20	721.61
	HSA	Single	449.21	367.20	183.60	41.00
		Empl + Child	1,167.86	488.40	244.20	339.73
		Empl + Spouse	1,225.82	488.40	244.20	368.71
		Family	1,648.45	488.40	244.20	580.03

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	462.38	367.20	183.60	47.59
		Empl + Child	1,202.24	488.40	244.20	356.92
		Empl + Spouse	1,262.32	488.40	244.20	386.96
		Family	1,696.78	488.40	244.20	604.19
	PPO	Single	526.37	367.20	183.60	79.58
		Empl + Child	1,368.48	488.40	244.20	440.04
		Empl + Spouse	1,436.39	488.40	244.20	473.99
		Family	1,931.62	488.40	244.20	721.61
	HSA	Single	449.21	367.20	183.60	41.00
		Empl + Child	1,167.86	488.40	244.20	339.73
		Empl + Spouse	1,225.82	488.40	244.20	368.71
		Family	1,648.45	488.40	244.20	580.03

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	321.00	160.50	32.16
		Empl + Child	1,001.87	520.00	260.00	240.94
		Empl + Spouse	1,051.93	520.00	260.00	265.97
		Family	1,413.98	569.00	284.50	422.49
	PPO	Single	438.64	321.00	160.50	58.82
		Empl + Child	1,140.40	520.00	260.00	310.20
		Empl + Spouse	1,196.99	520.00	260.00	338.50
		Family	1,609.68	569.00	284.50	520.34
	HSA	Single	374.34	321.00	160.50	26.67
		Empl + Child	973.22	520.00	260.00	226.61
		Empl + Spouse	1021.52	520.00	260.00	250.76
		Family	1,373.71	569.00	284.50	402.36

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer	HMO	Single	385.32	321.00	160.50	32.16
		Empl + Child	1,001.87	520.00	260.00	240.94
		Empl + Spouse	1,051.93	520.00	260.00	265.97
		Family	1,413.98	569.00	284.50	422.49
	PPO	Single	438.64	321.00	160.50	58.82
		Empl + Child	1,140.40	520.00	260.00	310.20
		Empl + Spouse	1,196.99	520.00	260.00	338.50
		Family	1,609.68	569.00	284.50	520.34
	HSA	Single	374.34	321.00	160.50	26.67
		Empl + Child	973.22	520.00	260.00	226.61
		Empl + Spouse	1021.52	520.00	260.00	250.76
		Family	1,373.71	569.00	284.50	402.36

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	321.00	160.50	32.16
		Empl + Child	1,001.87	427.00	213.50	287.44
		Empl + Spouse	1,051.93	427.00	213.50	312.47
		Family	1,413.98	427.00	203.50	493.49
	PPO	Single	438.64	321.00	160.50	58.82
		Empl + Child	1,140.40	427.00	213.50	356.70
		Empl + Spouse	1,196.99	427.00	213.50	385.00
		Family	1,609.68	427.00	213.50	591.34
	HSA	Single	374.34	321.00	160.50	26.67
		Empl + Child	973.22	427.00	213.50	273.11
		Empl + Spouse	1021.52	427.00	213.50	297.26
		Family	1,373.71	427.00	213.50	473.36

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	308.00	154.00	38.66
		Empl + Child	1,001.87	368.00	184.00	316.94
		Empl + Spouse	1,051.93	368.00	184.00	341.97
		Family	1,413.98	368.00	184.00	522.99
	PPO	Single	438.64	308.00	154.00	65.32
		Empl + Child	1,140.40	368.00	184.00	386.20
		Empl + Spouse	1,196.99	368.00	184.00	414.50
		Family	1,609.68	368.00	184.00	620.84
	HSA	Single	374.34	308.00	154.00	33.17
		Empl + Child	973.22	368.00	184.00	302.61
		Empl + Spouse	1021.52	368.00	184.00	326.76
		Family	1,373.71	368.00	184.00	502.86

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	268.00	134.00	58.66
		Empl + Child	1,001.87	336.00	168.00	332.94
		Empl + Spouse	1,051.93	336.00	168.00	357.97
		Family	1,413.98	336.00	168.00	538.99
	PPO	Single	438.64	268.00	134.00	85.32
		Empl + Child	1,140.40	336.00	168.00	402.20
		Empl + Spouse	1,196.99	336.00	168.00	430.50
		Family	1,609.68	336.00	168.00	636.84
	HSA	Single	374.34	268.00	134.00	53.17
		Empl + Child	973.22	336.00	168.00	318.61
		Empl + Spouse	1021.52	336.00	168.00	342.76
		Family	1,373.71	336.00	168.00	518.86

Service Manager/ Special Ed Transportation Mgr	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	385.32	306.00	153.00	39.66
		Empl + Child	1,001.87	793.00	396.50	104.44
		Empl + Spouse	1,051.93	793.00	396.50	129.47
		Family	1,413.98	1,058.00	529.00	177.99
	PPO	Single	438.64	306.00	153.00	66.32
		Empl + Child	1,140.40	793.00	396.50	173.70
		Empl + Spouse	1,196.99	793.00	396.50	202.00
		Family	1,609.68	1,058.00	529.00	275.84
	HSA	Single	374.34	306.00	153.00	34.17
		Empl + Child	973.22	793.00	396.50	90.11
		Empl + Spouse	1021.52	793.00	396.50	114.26
		Family	1,373.71	1,058.00	529.00	157.86

Anthem Rates by Position
July 15, 2008

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	433.19	216.60	0.04
		Empl + Child	1,126.69	1,126.61	563.31	0.04
		Empl + Spouse	1,183.00	1,182.92	591.46	0.04
		Family	1,590.18	1,590.10	795.05	0.04
	PPO	Single	475.3	475.22	237.61	0.04
		Empl + Child	1,235.80	1,235.72	617.86	0.04
		Empl + Spouse	1,297.16	1,297.08	648.54	0.04
		Family	1,744.34	1,744.26	872.13	0.04
	HSA	Single	384.15	384.07	192.04	0.04
		Empl + Child	998.80	998.72	499.36	0.04
		Empl + Spouse	1048.74	1,048.66	524.33	0.04
		Family	1,409.85	1,409.77	704.89	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	288.16	144.08	72.56
		Empl + Child	1,126.69	613.58	306.79	256.56
		Empl + Spouse	1,183.00	637.86	318.93	272.57
		Family	1,590.18	830.69	415.35	379.75
	PPO	Single	475.3	288.16	144.08	93.57
		Empl + Child	1,235.80	613.58	306.79	311.11
		Empl + Spouse	1,297.16	637.86	318.93	329.65
		Family	1,744.34	830.69	415.35	456.83
	HSA	Single	384.15	288.16	144.08	48.00
		Empl + Child	998.80	613.58	306.79	192.61
		Empl + Spouse	1048.74	637.86	318.93	205.44
		Family	1,409.85	830.69	415.35	289.58

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	144.08	72.04	144.60
		Empl + Child	1,126.69	306.79	153.40	409.95
		Empl + Spouse	1,183.00	318.93	159.47	432.04
		Family	1,590.18	415.35	207.67	587.42
	PPO	Single	475.3	144.08	72.04	165.61
		Empl + Child	1,235.80	306.79	153.40	464.51
		Empl + Spouse	1,297.16	318.93	159.47	489.12
		Family	1,744.34	415.35	207.67	664.50
	HSA	Single	384.15	144.08	72.04	120.04
		Empl + Child	998.80	306.79	153.40	346.01
		Empl + Spouse	1048.74	318.93	159.47	364.91
		Family	1,409.85	415.35	207.67	497.25

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,183.00	845.09	422.55	168.96
		Family	1,590.18	1,025.69	512.85	282.25
	PPO	Empl + Spouse	1,297.16	845.09	422.55	226.04
		Family	1,744.34	1,025.69	512.85	359.33
	HSA	Empl + Spouse	1048.74	845.09	422.55	101.83
		Family	1,409.85	1,025.69	512.85	192.08

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.92	392.40	196.20	63.76
		Empl + Child	1,352.03	522.00	261.00	415.01
		Empl + Spouse	1,419.60	522.00	261.00	448.80
		Family	1,908.22	522.00	261.00	693.11
	PPO	Single	570.36	392.40	196.20	88.98
		Empl + Child	1,482.96	522.00	261.00	480.48
		Empl + Spouse	1,556.59	522.00	261.00	517.30
		Family	2,093.21	522.00	261.00	785.60
	HSA	Single	460.98	392.40	196.20	34.29
		Empl + Child	1,198.56	522.00	261.00	338.28
		Empl + Spouse	1,258.49	522.00	261.00	368.24
		Family	1,691.82	522.00	261.00	584.91

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.92	392.40	196.20	63.76
		Empl + Child	1,352.03	522.00	261.00	415.01
		Empl + Spouse	1,419.60	522.00	261.00	448.80
		Family	1,908.22	522.00	261.00	693.11
	PPO	Single	570.36	392.40	196.20	88.98
		Empl + Child	1,482.96	522.00	261.00	480.48
		Empl + Spouse	1,556.59	522.00	261.00	517.30
		Family	2,093.21	522.00	261.00	785.60
	HSA	Single	460.98	392.40	196.20	34.29
		Empl + Child	1,198.56	522.00	261.00	338.28
		Empl + Spouse	1,258.49	522.00	261.00	368.24
		Family	1,691.82	522.00	261.00	584.91

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	350.00	175.00	41.64
		Empl + Child	1,126.69	567.00	283.50	279.85
		Empl + Spouse	1,183.00	567.00	283.50	308.00
		Family	1,590.18	621.00	310.50	484.59
	PPO	Single	475.30	350.00	175.00	62.65
		Empl + Child	1,235.80	567.00	283.50	334.40
		Empl + Spouse	1,297.16	567.00	283.50	365.08
		Family	1,744.34	621.00	310.50	561.67
	HSA	Single	384.15	350.00	175.00	17.08
		Empl + Child	998.80	567.00	283.50	215.90
		Empl + Spouse	1048.74	567.00	283.50	240.87
		Family	1,409.85	621.00	310.50	394.43

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer	HMO	Single	433.27	350.00	175.00	41.64
		Empl + Child	1,126.69	567.00	283.50	279.85
		Empl + Spouse	1,183.00	567.00	283.50	308.00
		Family	1,590.18	621.00	310.50	484.59
	PPO	Single	475.30	350.00	175.00	62.65
		Empl + Child	1,235.80	567.00	283.50	334.40
		Empl + Spouse	1,297.16	567.00	283.50	365.08
		Family	1,744.34	621.00	310.50	561.67
	HSA	Single	384.15	350.00	175.00	17.08
		Empl + Child	998.80	567.00	283.50	215.90
		Empl + Spouse	1048.74	567.00	283.50	240.87
		Family	1,409.85	621.00	310.50	394.43

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	327.00	163.50	53.14
		Empl + Child	1,126.69	435.00	217.50	345.85
		Empl + Spouse	1,183.00	435.00	217.50	374.00
		Family	1,590.18	435.00	217.50	577.59
	PPO	Single	475.30	327.00	163.50	74.15
		Empl + Child	1,235.80	435.00	217.50	400.40
		Empl + Spouse	1,297.16	435.00	217.50	431.08
		Family	1,744.34	435.00	217.50	654.67
	HSA	Single	384.15	327.00	163.50	28.58
		Empl + Child	998.80	435.00	217.50	281.90
		Empl + Spouse	1048.74	435.00	217.50	306.87
		Family	1,409.85	435.00	217.50	487.43

12- Month Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	350.00	175.00	41.64
		Empl + Child	1,126.69	465.00	232.50	330.85
		Empl + Spouse	1,183.00	465.00	232.50	359.00
		Family	1,590.18	465.00	217.50	562.59
	PPO	Single	475.30	350.00	175.00	62.65
		Empl + Child	1,235.80	465.00	232.50	385.40
		Empl + Spouse	1,297.16	465.00	232.50	416.08
		Family	1,744.34	465.00	232.50	639.67
	HSA	Single	384.15	350.00	175.00	17.08
		Empl + Child	998.80	465.00	232.50	266.90
		Empl + Spouse	1048.74	465.00	232.50	291.87
		Family	1,409.85	465.00	232.50	472.43

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	330.00	165.00	51.64
		Empl + Child	1,126.69	394.00	197.00	366.35
		Empl + Spouse	1,183.00	394.00	197.00	394.50
		Family	1,590.18	394.00	197.00	598.09
	PPO	Single	475.30	330.00	165.00	72.65
		Empl + Child	1,235.80	394.00	197.00	420.90
		Empl + Spouse	1,297.16	394.00	197.00	451.58
		Family	1,744.34	394.00	197.00	675.17
	HSA	Single	384.15	330.00	165.00	27.08
		Empl + Child	998.80	394.00	197.00	302.40
		Empl + Spouse	1048.74	394.00	197.00	327.37
		Family	1,409.85	394.00	197.00	507.93

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	287.00	143.50	73.14
		Empl + Child	1,126.69	360.00	180.00	383.35
		Empl + Spouse	1,183.00	360.00	180.00	411.50
		Family	1,590.18	360.00	180.00	615.09
	PPO	Single	475.30	287.00	143.50	94.15
		Empl + Child	1,235.80	360.00	180.00	437.90
		Empl + Spouse	1,297.16	360.00	180.00	468.58
		Family	1,744.34	360.00	180.00	692.17
	HSA	Single	384.15	287.00	143.50	48.58
		Empl + Child	998.80	360.00	180.00	319.40
		Empl + Spouse	1048.74	360.00	180.00	344.37
		Family	1,409.85	360.00	180.00	524.93

Transportation Office Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	350.00	175.00	41.64
		Empl + Child	1,126.69	908.00	454.00	109.35
		Empl + Spouse	1,183.00	908.00	454.00	137.50
		Family	1,590.18	1,211.00	605.50	189.59
	PPO	Single	475.30	350.00	175.00	62.65
		Empl + Child	1,235.80	908.00	454.00	163.90
		Empl + Spouse	1,297.16	908.00	454.00	194.58
		Family	1,744.34	1,211.00	605.50	266.67
	HSA	Single	384.15	350.00	175.00	17.08
		Empl + Child	998.80	908.00	454.00	45.40
		Empl + Spouse	1048.74	908.00	454.00	70.37
		Family	1,409.85	1,211.00	605.50	99.43

Anthem Rates by Position
September 1, 2008

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	433.19	216.60	0.04
		Empl + Child	1,126.69	1,126.61	563.31	0.04
		Empl + Spouse	1,183.00	1,182.92	591.46	0.04
		Family	1,590.18	1,590.10	795.05	0.04
	PPO	Single	475.30	475.22	237.61	0.04
		Empl + Child	1,235.80	1,235.72	617.86	0.04
		Empl + Spouse	1,297.16	1,297.08	648.54	0.04
		Family	1,744.34	1,744.26	872.13	0.04
	HSA	Single	384.15	384.07	192.04	0.04
		Empl + Child	998.80	998.72	499.36	0.04
		Empl + Spouse	1048.74	1,048.66	524.33	0.04
		Family	1,409.85	1,409.77	704.89	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	288.16	144.08	72.56
		Empl + Child	1,126.69	613.58	306.79	256.56
		Empl + Spouse	1,183.00	637.86	318.93	272.57
		Family	1,590.18	830.69	415.35	379.75
	PPO	Single	475.30	288.16	144.08	93.57
		Empl + Child	1,235.80	613.58	306.79	311.11
		Empl + Spouse	1,297.16	637.86	318.93	329.65
		Family	1,744.34	830.69	415.35	456.83
	HSA	Single	384.15	288.16	144.08	48.00
		Empl + Child	998.80	613.58	306.79	192.61
		Empl + Spouse	1048.74	637.86	318.93	205.44
		Family	1,409.85	830.69	415.35	289.58

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	144.08	72.04	144.60
		Empl + Child	1,126.69	306.79	153.40	409.95
		Empl + Spouse	1,183.00	318.93	159.47	432.04
		Family	1,590.18	415.35	207.67	587.42
	PPO	Single	475.30	144.08	72.04	165.61
		Empl + Child	1,235.80	306.79	153.40	464.51
		Empl + Spouse	1,297.16	318.93	159.47	489.12
		Family	1,744.34	415.35	207.67	664.50
	HSA	Single	384.15	144.08	72.04	120.04
		Empl + Child	998.80	306.79	153.40	346.01
		Empl + Spouse	1048.74	318.93	159.47	364.91
		Family	1,409.85	415.35	207.67	497.25

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,183.00	845.09	422.55	168.96
		Family	1,590.18	1,025.69	512.85	282.25
	PPO	Empl + Spouse	1,297.16	845.09	422.55	226.04
		Family	1,744.34	1,025.69	512.85	359.33
	HSA	Empl + Spouse	1048.74	845.09	422.55	101.83
		Family	1,409.85	1,025.69	512.85	192.08

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.92	420.00	210.00	49.96
		Empl + Child	1,352.03	558.00	279.00	397.01
		Empl + Spouse	1,419.60	558.00	279.00	430.80
		Family	1,908.22	558.00	279.00	675.11
	PPO	Single	570.36	420.00	210.00	75.18
		Empl + Child	1,482.96	558.00	279.00	462.48
		Empl + Spouse	1,556.59	558.00	279.00	499.30
		Family	2,093.21	558.00	279.00	767.60
	HSA	Single	460.98	420.00	210.00	20.49
		Empl + Child	1,198.56	558.00	279.00	320.28
		Empl + Spouse	1,258.49	558.00	279.00	350.24
		Family	1,691.82	558.00	279.00	566.91

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.92	420.00	210.00	49.96
		Empl + Child	1,352.03	558.00	279.00	397.01
		Empl + Spouse	1,419.60	558.00	279.00	430.80
		Family	1,908.22	558.00	279.00	675.11
	PPO	Single	570.36	420.00	210.00	75.18
		Empl + Child	1,482.96	558.00	279.00	462.48
		Empl + Spouse	1,556.59	558.00	279.00	499.30
		Family	2,093.21	558.00	279.00	767.60
	HSA	Single	460.98	420.00	210.00	20.49
		Empl + Child	1,198.56	558.00	279.00	320.28
		Empl + Spouse	1,258.49	558.00	279.00	350.24
		Family	1,691.82	558.00	279.00	566.91

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	350.00	175.00	41.64
		Empl + Child	1,126.69	567.00	283.50	279.85
		Empl + Spouse	1,183.00	567.00	283.50	308.00
		Family	1,590.18	621.00	310.50	484.59
	PPO	Single	475.30	350.00	175.00	62.65
		Empl + Child	1,235.80	567.00	283.50	334.40
		Empl + Spouse	1,297.16	567.00	283.50	365.08
		Family	1,744.34	621.00	310.50	561.67
	HSA	Single	384.15	350.00	175.00	17.08
		Empl + Child	998.80	567.00	283.50	215.90
		Empl + Spouse	1048.74	567.00	283.50	240.87
		Family	1,409.85	621.00	310.50	394.43

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer	HMO	Single	433.27	350.00	175.00	41.64
		Empl + Child	1,126.69	567.00	283.50	279.85
		Empl + Spouse	1,183.00	567.00	283.50	308.00
		Family	1,590.18	621.00	310.50	484.59
	PPO	Single	475.30	350.00	175.00	62.65
		Empl + Child	1,235.80	567.00	283.50	334.40
		Empl + Spouse	1,297.16	567.00	283.50	365.08
		Family	1,744.34	621.00	310.50	561.67
	HSA	Single	384.15	350.00	175.00	17.08
		Empl + Child	998.80	567.00	283.50	215.90
		Empl + Spouse	1048.74	567.00	283.50	240.87
		Family	1,409.85	621.00	310.50	394.43

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	350.00	175.00	41.64
		Empl + Child	1,126.69	465.00	232.50	330.85
		Empl + Spouse	1,183.00	465.00	232.50	359.00
		Family	1,590.18	465.00	217.50	562.59
	PPO	Single	475.30	350.00	175.00	62.65
		Empl + Child	1,235.80	465.00	232.50	385.40
		Empl + Spouse	1,297.16	465.00	232.50	416.08
		Family	1,744.34	465.00	232.50	639.67
	HSA	Single	384.15	350.00	175.00	17.08
		Empl + Child	998.80	465.00	232.50	266.90
		Empl + Spouse	1048.74	465.00	232.50	291.87
		Family	1,409.85	465.00	232.50	472.43

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	353.00	176.50	40.14
		Empl + Child	1,126.69	422.00	211.00	352.35
		Empl + Spouse	1,183.00	422.00	211.00	380.50
		Family	1,590.18	422.00	211.00	584.09
	PPO	Single	475.30	353.00	176.50	61.15
		Empl + Child	1,235.80	422.00	211.00	406.90
		Empl + Spouse	1,297.16	422.00	211.00	437.58
		Family	1,744.34	422.00	211.00	661.17
	HSA	Single	384.15	353.00	176.50	15.58
		Empl + Child	998.80	422.00	211.00	288.40
		Empl + Spouse	1048.74	422.00	211.00	313.37
		Family	1,409.85	422.00	211.00	493.93

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	307.00	153.50	63.14
		Empl + Child	1,126.69	385.00	192.50	370.85
		Empl + Spouse	1,183.00	385.00	192.50	399.00
		Family	1,590.18	385.00	192.50	602.59
	PPO	Single	475.30	307.00	153.50	84.15
		Empl + Child	1,235.80	385.00	192.50	425.40
		Empl + Spouse	1,297.16	385.00	192.50	456.08
		Family	1,744.34	385.00	192.50	679.67
	HSA	Single	384.15	307.00	153.50	38.58
		Empl + Child	998.80	385.00	192.50	306.90
		Empl + Spouse	1048.74	385.00	192.50	331.87
		Family	1,409.85	385.00	192.50	512.43

Transportation Office Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	433.27	350.00	175.00	41.64
		Empl + Child	1,126.69	908.00	454.00	109.35
		Empl + Spouse	1,183.00	908.00	454.00	137.50
		Family	1,590.18	1,211.00	605.50	189.59
	PPO	Single	475.30	350.00	175.00	62.65
		Empl + Child	1,235.80	908.00	454.00	163.90
		Empl + Spouse	1,297.16	908.00	454.00	194.58
		Family	1,744.34	1,211.00	605.50	266.67
	HSA	Single	384.15	350.00	175.00	17.08
		Empl + Child	998.80	908.00	454.00	45.40
		Empl + Spouse	1048.74	908.00	454.00	70.37
		Family	1,409.85	1,211.00	605.50	99.43

Anthem Rates by Position
December 15, 2008

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	472.18	236.09	0.04
		Empl + Child	1,228.09	1,228.01	614.01	0.04
		Empl + Spouse	1,289.47	1,289.39	644.70	0.04
		Family	1,733.30	1,733.22	866.61	0.04
	PPO	Single	522.83	522.75	261.38	0.04
		Empl + Child	1,359.38	1,359.30	679.65	0.04
		Empl + Spouse	1,426.88	1,426.80	713.40	0.04
		Family	1,918.77	1,918.69	959.35	0.04
	HSA	Single	418.72	418.64	209.32	0.04
		Empl + Child	1,088.69	1,088.61	544.31	0.04
		Empl + Spouse	1,143.13	1,143.05	571.53	0.04
		Family	1,536.74	1,536.66	768.33	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	308.33	154.17	81.97
		Empl + Child	1,228.09	656.53	328.27	285.78
		Empl + Spouse	1,289.47	682.51	341.26	303.48
		Family	1,733.30	888.84	444.42	422.23
	PPO	Single	522.83	308.33	154.17	107.25
		Empl + Child	1,359.38	656.53	328.27	351.43
		Empl + Spouse	1,426.88	682.51	341.26	372.19
		Family	1,918.77	888.84	444.42	514.97
	HSA	Single	418.72	308.33	154.17	55.20
		Empl + Child	1,088.69	656.53	328.27	216.08
		Empl + Spouse	1,143.13	682.51	341.26	230.31
		Family	1,536.74	888.84	444.42	323.95

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	154.17	77.08	159.05
		Empl + Child	1,228.09	328.27	164.13	449.91
		Empl + Spouse	1,289.47	341.26	170.63	474.11
		Family	1,733.30	444.42	222.21	644.44
	PPO	Single	522.83	154.17	77.08	184.33
		Empl + Child	1,359.38	328.27	164.13	515.56
		Empl + Spouse	1,426.88	341.26	170.63	542.81
		Family	1,918.77	444.42	222.21	737.18
	HSA	Single	418.72	154.17	77.08	132.28
		Empl + Child	1,088.69	328.27	164.13	380.21
		Empl + Spouse	1,143.13	341.26	170.63	400.94
		Family	1,536.74	444.42	222.21	546.16

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,289.47	904.24	452.12	192.62
		Family	1,733.30	1,097.49	548.75	317.91
	PPO	Empl + Spouse	1,426.88	904.24	452.12	261.32
		Family	1,918.77	1,097.49	548.75	410.64
	HSA	Empl + Spouse	1,143.13	904.24	452.12	119.45
		Family	1,536.74	1,097.49	548.75	219.63

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.72	420.00	210.00	73.36
		Empl + Child	1,473.71	558.00	279.00	457.85
		Empl + Spouse	1,547.36	558.00	279.00	494.68
		Family	2,079.96	558.00	279.00	760.98
	PPO	Single	627.40	420.00	210.00	103.70
		Empl + Child	1,631.26	558.00	279.00	536.63
		Empl + Spouse	1,712.25	558.00	279.00	577.13
		Family	2,302.53	558.00	279.00	872.27
	HSA	Single	502.47	420.00	210.00	41.24
		Empl + Child	1,306.43	558.00	279.00	374.21
		Empl + Spouse	1,371.75	558.00	279.00	406.88
		Family	1,844.08	558.00	279.00	643.04

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.72	420.00	210.00	73.36
		Empl + Child	1,473.71	558.00	279.00	457.85
		Empl + Spouse	1,547.36	558.00	279.00	494.68
		Family	2,079.96	558.00	279.00	760.98
	PPO	Single	627.40	420.00	210.00	103.70
		Empl + Child	1,631.26	558.00	279.00	536.63
		Empl + Spouse	1,712.25	558.00	279.00	577.13
		Family	2,302.53	558.00	279.00	872.27
	HSA	Single	502.47	420.00	210.00	41.24
		Empl + Child	1,306.43	558.00	279.00	374.22
		Empl + Spouse	1,371.75	558.00	279.00	406.88
		Family	1,844.08	558.00	279.00	643.04

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	350.00	175.00	61.13
		Empl + Child	1,228.09	567.00	283.50	330.55
		Empl + Spouse	1,289.47	567.00	283.50	361.24
		Family	1,733.30	621.00	310.50	556.15
	PPO	Single	522.83	350.00	175.00	86.42
		Empl + Child	1,359.38	567.00	283.50	396.19
		Empl + Spouse	1,426.88	567.00	283.50	429.94
		Family	1,918.77	621.00	310.50	648.89
	HSA	Single	418.72	350.00	175.00	34.36
		Empl + Child	1,088.69	567.00	283.50	260.85
		Empl + Spouse	1,143.13	567.00	283.50	288.07
		Family	1,536.74	621.00	310.50	457.87

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer	HMO	Single	472.26	350.00	175.00	61.13
		Empl + Child	1,228.09	567.00	283.50	330.55
		Empl + Spouse	1,289.47	567.00	283.50	361.24
		Family	1,733.30	621.00	310.50	556.15
	PPO	Single	522.83	350.00	175.00	86.42
		Empl + Child	1,359.38	567.00	283.50	396.19
		Empl + Spouse	1,426.88	567.00	283.50	429.94
		Family	1,918.77	621.00	310.50	648.89
	HSA	Single	418.72	350.00	175.00	34.36
		Empl + Child	1,088.69	567.00	283.50	260.85
		Empl + Spouse	1,143.13	567.00	283.50	288.07
		Family	1,536.74	621.00	310.50	457.87

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	350.00	175.00	61.13
		Empl + Child	1,228.09	465.00	232.50	381.55
		Empl + Spouse	1,289.47	465.00	232.50	412.24
		Family	1,733.30	465.00	217.50	634.15
	PPO	Single	522.83	350.00	175.00	86.42
		Empl + Child	1,359.38	465.00	232.50	447.19
		Empl + Spouse	1,426.88	465.00	232.50	480.94
		Family	1,918.77	465.00	232.50	726.89
	HSA	Single	418.72	350.00	175.00	34.36
		Empl + Child	1,088.69	465.00	232.50	311.85
		Empl + Spouse	1,143.13	465.00	232.50	339.07
		Family	1,536.74	465.00	232.50	535.87

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	353.00	176.50	59.63
		Empl + Child	1,228.09	422.00	211.00	403.05
		Empl + Spouse	1,289.47	422.00	211.00	433.74
		Family	1,733.30	422.00	211.00	655.65
	PPO	Single	522.83	353.00	176.50	84.92
		Empl + Child	1,359.38	422.00	211.00	468.69
		Empl + Spouse	1,426.88	422.00	211.00	502.44
		Family	1,918.77	422.00	211.00	748.39
	HSA	Single	418.72	353.00	176.50	32.86
		Empl + Child	1,088.69	422.00	211.00	333.35
		Empl + Spouse	1,143.13	422.00	211.00	360.57
		Family	1,536.74	422.00	211.00	557.37

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	307.00	153.50	82.63
		Empl + Child	1,228.09	385.00	192.50	421.55
		Empl + Spouse	1,289.47	385.00	192.50	452.24
		Family	1,733.30	385.00	192.50	674.15
	PPO	Single	522.83	307.00	153.50	107.92
		Empl + Child	1,359.38	385.00	192.50	487.19
		Empl + Spouse	1,426.88	385.00	192.50	520.94
		Family	1,918.77	385.00	192.50	766.89
	HSA	Single	418.72	307.00	153.50	55.86
		Empl + Child	1,088.69	385.00	192.50	351.85
		Empl + Spouse	1,143.13	385.00	192.50	379.07
		Family	1,536.74	385.00	192.50	575.87

Transportation Office Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	350.00	175.00	61.13
		Empl + Child	1,228.09	908.00	454.00	160.05
		Empl + Spouse	1,289.47	908.00	454.00	190.74
		Family	1,733.30	1,211.00	605.50	261.15
	PPO	Single	522.83	350.00	175.00	86.42
		Empl + Child	1,359.38	908.00	454.00	225.69
		Empl + Spouse	1,426.88	908.00	454.00	259.44
		Family	1,918.77	1,211.00	605.50	353.89
	HSA	Single	418.72	350.00	175.00	34.36
		Empl + Child	1,088.69	908.00	454.00	90.35
		Empl + Spouse	1,143.13	908.00	454.00	117.57
		Family	1,536.74	1,211.00	605.50	162.87

Anthem Rates by Position
September 1, 2009

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	472.18	236.09	0.04
		Empl + Child	1,228.09	1,228.01	614.01	0.04
		Empl + Spouse	1,289.47	1,289.39	644.70	0.04
		Family	1,733.30	1,733.22	866.61	0.04
	PPO	Single	522.83	522.75	261.38	0.04
		Empl + Child	1,359.38	1,359.30	679.65	0.04
		Empl + Spouse	1,426.88	1,426.80	713.40	0.04
		Family	1,918.77	1,918.69	959.35	0.04
	HSA	Single	418.72	418.64	209.32	0.04
		Empl + Child	1,088.69	1,088.61	544.31	0.04
		Empl + Spouse	1,143.13	1,143.05	571.53	0.04
		Family	1,536.74	1,536.66	768.33	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	308.33	154.17	81.97
		Empl + Child	1,228.09	656.53	328.27	285.78
		Empl + Spouse	1,289.47	682.51	341.26	303.48
		Family	1,733.30	888.84	444.42	422.23
	PPO	Single	522.83	308.33	154.17	107.25
		Empl + Child	1,359.38	656.53	328.27	351.43
		Empl + Spouse	1,426.88	682.51	341.26	372.19
		Family	1,918.77	888.84	444.42	514.97
	HSA	Single	418.72	308.33	154.17	55.20
		Empl + Child	1,088.69	656.53	328.27	216.08
		Empl + Spouse	1,143.13	682.51	341.26	230.31
		Family	1,536.74	888.84	444.42	323.95

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	154.17	77.08	159.05
		Empl + Child	1,228.09	328.27	164.13	449.91
		Empl + Spouse	1,289.47	341.26	170.63	474.11
		Family	1,733.30	444.42	222.21	644.44
	PPO	Single	522.83	154.17	77.08	184.33
		Empl + Child	1,359.38	328.27	164.13	515.56
		Empl + Spouse	1,426.88	341.26	170.63	542.81
		Family	1,918.77	444.42	222.21	737.18
	HSA	Single	418.72	154.17	77.08	132.28
		Empl + Child	1,088.69	328.27	164.13	380.21
		Empl + Spouse	1,143.13	341.26	170.63	400.94
		Family	1,536.74	444.42	222.21	546.16

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,289.47	904.24	452.12	192.62
		Family	1,733.30	1,097.49	548.75	317.91
	PPO	Empl + Spouse	1,426.88	904.24	452.12	261.32
		Family	1,918.77	1,097.49	548.75	410.64
	HSA	Empl + Spouse	1,143.13	904.24	452.12	119.45
		Family	1,536.74	1,097.49	548.75	219.63

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.72	450.00	225.00	58.36
		Empl + Child	1,473.71	597.60	298.80	438.05
		Empl + Spouse	1,547.36	597.60	298.80	474.88
		Family	2,079.96	597.60	298.80	741.18
	PPO	Single	627.40	450.00	225.00	88.70
		Empl + Child	1,631.26	597.60	298.80	516.83
		Empl + Spouse	1,712.25	597.60	298.80	557.33
		Family	2,302.53	597.60	298.80	852.47
	HSA	Single	502.47	450.00	225.00	26.24
		Empl + Child	1,306.43	597.60	298.80	354.41
		Empl + Spouse	1,371.75	597.60	298.80	387.08
		Family	1,844.08	597.60	298.80	623.24

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.72	450.00	225.00	58.36
		Empl + Child	1,473.71	597.60	298.80	438.05
		Empl + Spouse	1,547.36	597.60	298.80	474.88
		Family	2,079.96	597.60	298.80	741.18
	PPO	Single	627.40	450.00	225.00	88.70
		Empl + Child	1,631.26	597.60	298.80	516.83
		Empl + Spouse	1,712.25	597.60	298.80	557.33
		Family	2,302.53	597.60	298.80	852.47
	HSA	Single	502.47	450.00	225.00	26.24
		Empl + Child	1,306.43	597.60	298.80	354.42
		Empl + Spouse	1,371.75	597.60	298.80	387.08
		Family	1,844.08	597.60	298.80	623.24

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	375.00	187.50	48.63
		Empl + Child	1,228.09	607.00	303.50	310.55
		Empl + Spouse	1,289.47	607.00	303.50	341.24
		Family	1,733.30	664.00	332.00	534.65
	PPO	Single	522.83	375.00	187.50	73.92
		Empl + Child	1,359.38	607.00	303.50	376.19
		Empl + Spouse	1,426.88	607.00	303.50	409.94
		Family	1,918.77	664.00	332.00	627.39
	HSA	Single	418.72	375.00	187.50	21.86
		Empl + Child	1,088.69	607.00	303.50	240.85
		Empl + Spouse	1,143.13	607.00	303.50	268.07
		Family	1,536.74	664.00	332.00	436.37

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer *Grade Reporting Specialist	HMO	Single	472.26	375.00	187.50	48.63
		Empl + Child	1,228.09	607.00	303.50	310.55
		Empl + Spouse	1,289.47	607.00	303.50	341.24
		Family	1,733.30	664.00	332.00	534.65
	PPO	Single	522.83	375.00	187.50	73.92
		Empl + Child	1,359.38	607.00	303.50	376.19
		Empl + Spouse	1,426.88	607.00	303.50	409.94
		Family	1,918.77	664.00	332.00	627.39
	HSA	Single	418.72	375.00	187.50	21.86
		Empl + Child	1,088.69	607.00	303.50	240.85
		Empl + Spouse	1,143.13	607.00	303.50	268.07
		Family	1,536.74	664.00	332.00	436.37

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	375.00	187.50	48.63
		Empl + Child	1,228.09	498.00	249.00	365.05
		Empl + Spouse	1,289.47	498.00	249.00	395.74
		Family	1,733.30	498.00	249.00	617.65
	PPO	Single	522.83	375.00	187.50	73.92
		Empl + Child	1,359.38	498.00	249.00	430.69
		Empl + Spouse	1,426.88	498.00	249.00	464.44
		Family	1,918.77	498.00	249.00	710.39
	HSA	Single	418.72	375.00	187.50	21.86
		Empl + Child	1,088.69	498.00	249.00	295.35
		Empl + Spouse	1,143.13	498.00	249.00	322.57
		Family	1,536.74	498.00	249.00	519.37

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	378.00	189.00	47.13
		Empl + Child	1,228.09	452.00	226.00	388.05
		Empl + Spouse	1,289.47	452.00	226.00	418.74
		Family	1,733.30	452.00	226.00	640.65
	PPO	Single	522.83	378.00	189.00	72.42
		Empl + Child	1,359.38	452.00	226.00	453.69
		Empl + Spouse	1,426.88	452.00	226.00	487.44
		Family	1,918.77	452.00	226.00	733.39
	HSA	Single	418.72	378.00	189.00	20.36
		Empl + Child	1,088.69	452.00	226.00	318.35
		Empl + Spouse	1,143.13	452.00	226.00	345.57
		Family	1,536.74	452.00	226.00	542.37

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	328.00	164.00	72.13
		Empl + Child	1,228.09	412.00	206.00	408.05
		Empl + Spouse	1,289.47	412.00	206.00	438.74
		Family	1,733.30	412.00	206.00	660.65
	PPO	Single	522.83	328.00	164.00	97.42
		Empl + Child	1,359.38	412.00	206.00	473.69
		Empl + Spouse	1,426.88	412.00	206.00	507.44
		Family	1,918.77	412.00	206.00	753.39
	HSA	Single	418.72	328.00	164.00	45.36
		Empl + Child	1,088.69	412.00	206.00	338.35
		Empl + Spouse	1,143.13	412.00	206.00	365.57
		Family	1,536.74	412.00	206.00	562.37

Transportation Office Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	472.26	375.00	187.50	48.63
		Empl + Child	1,228.09	972.00	486.00	128.05
		Empl + Spouse	1,289.47	972.00	486.00	158.74
		Family	1,733.30	1,296.00	648.00	218.65
	PPO	Single	522.83	375.00	187.50	73.92
		Empl + Child	1,359.38	972.00	486.00	193.69
		Empl + Spouse	1,426.88	972.00	486.00	227.44
		Family	1,918.77	1,296.00	648.00	311.39
	HSA	Single	418.72	375.00	187.50	21.86
		Empl + Child	1,088.69	972.00	486.00	58.35
		Empl + Spouse	1,143.13	972.00	486.00	85.57
		Family	1,536.74	1,296.00	648.00	120.37

Anthem Rates by Position
December 15, 2009

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.49	519.41	259.71	0.04
		Empl + Child	1,350.90	1,350.82	675.41	0.04
		Empl + Spouse	1,418.42	1,418.34	709.17	0.04
		Family	1,906.63	1,906.55	953.28	0.04
	PPO	Single	575.11	575.03	287.52	0.04
		Empl + Child	1,495.32	1,495.24	747.62	0.04
		Empl + Spouse	1,569.57	1,569.49	784.75	0.04
		Family	2,110.65	2,110.57	1,055.29	0.04
	HSA	Single	460.59	460.51	230.26	0.04
		Empl + Child	1,197.56	1,197.48	598.74	0.04
		Empl + Spouse	1,257.44	1,257.36	628.68	0.04
		Family	1,690.41	1,690.33	845.17	0.04

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.49	329.92	164.96	94.79
		Empl + Child	1,350.90	702.49	351.25	324.21
		Empl + Spouse	1,418.42	730.28	365.14	344.07
		Family	1,906.63	951.06	475.53	477.79
	PPO	Single	575.11	329.92	164.96	122.60
		Empl + Child	1,495.32	702.49	351.25	396.42
		Empl + Spouse	1,569.57	730.28	365.14	419.65
		Family	2,110.65	951.06	475.53	579.80
	HSA	Single	460.59	329.92	164.96	65.34
		Empl + Child	1,197.56	702.49	351.25	247.54
		Empl + Spouse	1,257.44	730.28	365.14	263.58
		Family	1,690.41	951.06	475.53	369.68

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.49	164.96	82.48	177.27
		Empl + Child	1,350.90	351.25	175.62	499.83
		Empl + Spouse	1,418.42	365.14	182.57	526.64
		Family	1,906.63	475.53	237.77	715.55
	PPO	Single	575.11	164.96	82.48	205.08
		Empl + Child	1,495.32	351.25	175.62	572.04
		Empl + Spouse	1,569.57	365.14	182.57	602.22
		Family	2,110.65	475.53	237.77	817.56
	HSA	Single	460.59	164.96	82.48	147.82
		Empl + Child	1,197.56	351.25	175.62	423.16
		Empl + Spouse	1,257.44	365.14	182.57	446.15
		Family	1,690.41	475.53	237.77	607.44

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,418.42	967.54	483.77	225.44
		Family	1,906.63	1,174.31	587.16	366.16
	PPO	Empl + Spouse	1,569.57	967.54	483.77	301.02
		Family	2,110.65	1,174.31	587.16	468.17
	HSA	Empl + Spouse	1,257.44	967.54	483.77	144.95
		Family	1,690.41	1,174.31	587.16	258.05

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	623.39	450.00	225.00	86.69
		Empl + Child	1,621.08	597.60	298.80	511.74
		Empl + Spouse	1,702.10	597.60	298.80	552.25
		Family	2,287.96	597.60	298.80	845.18
	PPO	Single	690.13	450.00	225.00	120.07
		Empl + Child	1,794.38	597.60	298.80	598.39
		Empl + Spouse	1,883.48	597.60	298.80	642.94
		Family	2,532.78	597.60	298.80	967.59
	HSA	Single	552.71	450.00	225.00	51.35
		Empl + Child	1,437.07	597.60	298.80	419.74
		Empl + Spouse	1,508.93	597.60	298.80	455.66
		Family	2,028.49	597.60	298.80	715.45

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	623.39	450.00	225.00	86.69
		Empl + Child	1,621.08	597.60	298.80	511.74
		Empl + Spouse	1,702.10	597.60	298.80	552.25
		Family	2,287.96	597.60	298.80	845.18
	PPO	Single	690.13	450.00	225.00	120.07
		Empl + Child	1,794.38	597.60	298.80	598.39
		Empl + Spouse	1,883.48	597.60	298.80	642.94
		Family	2,532.78	597.60	298.80	967.59
	HSA	Single	552.71	450.00	225.00	51.35
		Empl + Child	1,437.07	597.60	298.80	419.74
		Empl + Spouse	1,508.93	597.60	298.80	455.66
		Family	2,028.49	597.60	298.80	715.45

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.49	375.00	187.50	72.25
		Empl + Child	1,350.90	607.00	303.50	371.95
		Empl + Spouse	1,418.42	607.00	303.50	405.71
		Family	1,906.63	664.00	332.00	621.32
	PPO	Single	575.11	375.00	187.50	100.06
		Empl + Child	1,495.32	607.00	303.50	444.16
		Empl + Spouse	1,569.57	607.00	303.50	481.29
		Family	2,110.65	664.00	332.00	723.33
	HSA	Single	460.59	375.00	187.50	42.80
		Empl + Child	1,197.56	607.00	303.50	295.28
		Empl + Spouse	1,257.44	607.00	303.50	325.22
		Family	1,690.41	664.00	332.00	513.21

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer *Grade Reporting Specialist	HMO	Single	519.49	375.00	187.50	72.25
		Empl + Child	1,350.90	607.00	303.50	371.95
		Empl + Spouse	1,418.42	607.00	303.50	405.71
		Family	1,906.63	664.00	332.00	621.32
	PPO	Single	575.11	375.00	187.50	100.06
		Empl + Child	1,495.32	607.00	303.50	444.16
		Empl + Spouse	1,569.57	607.00	303.50	481.29
		Family	2,110.65	664.00	332.00	723.33
	HSA	Single	460.59	375.00	187.50	42.80
		Empl + Child	1,197.56	607.00	303.50	295.28
		Empl + Spouse	1,257.44	607.00	303.50	325.22
		Family	1,690.41	664.00	332.00	513.21

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.49	375.00	187.50	72.25
		Empl + Child	1,350.90	498.00	249.00	426.45
		Empl + Spouse	1,418.42	498.00	249.00	460.21
		Family	1,906.63	498.00	249.00	704.32
	PPO	Single	575.11	375.00	187.50	100.06
		Empl + Child	1,495.32	498.00	249.00	498.66
		Empl + Spouse	1,569.57	498.00	249.00	535.79
		Family	2,110.65	498.00	249.00	806.33
	HSA	Single	460.59	375.00	187.50	42.80
		Empl + Child	1,197.56	498.00	249.00	349.78
		Empl + Spouse	1,257.44	498.00	249.00	379.72
		Family	1,690.41	498.00	249.00	596.21

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.49	378.00	189.00	70.75
		Empl + Child	1,350.90	452.00	226.00	449.45
		Empl + Spouse	1,418.42	452.00	226.00	483.21
		Family	1,906.63	452.00	226.00	727.32
	PPO	Single	575.11	378.00	189.00	98.56
		Empl + Child	1,495.32	452.00	226.00	521.66
		Empl + Spouse	1,569.57	452.00	226.00	558.79
		Family	2,110.65	452.00	226.00	829.33
	HSA	Single	460.59	378.00	189.00	41.30
		Empl + Child	1,197.56	452.00	226.00	372.78
		Empl + Spouse	1,257.44	452.00	226.00	402.72
		Family	1,690.41	452.00	226.00	619.21

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.49	328.00	164.00	95.75
		Empl + Child	1,350.90	412.00	206.00	469.45
		Empl + Spouse	1,418.42	412.00	206.00	503.21
		Family	1,906.63	412.00	206.00	747.32
	PPO	Single	575.11	328.00	164.00	123.56
		Empl + Child	1,495.32	412.00	206.00	541.66
		Empl + Spouse	1,569.57	412.00	206.00	578.79
		Family	2,110.65	412.00	206.00	849.33
	HSA	Single	460.59	328.00	164.00	66.30
		Empl + Child	1,197.56	412.00	206.00	392.78
		Empl + Spouse	1,257.44	412.00	206.00	422.72
		Family	1,690.41	412.00	206.00	639.21

Transportation Office Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	519.49	375.00	187.50	72.25
		Empl + Child	1,350.90	972.00	486.00	189.45
		Empl + Spouse	1,418.42	972.00	486.00	223.21
		Family	1,906.63	1,296.00	648.00	305.32
	PPO	Single	575.11	375.00	187.50	100.06
		Empl + Child	1,495.32	972.00	486.00	261.66
		Empl + Spouse	1,569.57	972.00	486.00	298.79
		Family	2,110.65	1,296.00	648.00	407.33
	HSA	Single	460.59	375.00	187.50	42.80
		Empl + Child	1,197.56	972.00	486.00	112.78
		Empl + Spouse	1,257.44	972.00	486.00	142.72
		Family	1,690.41	1,296.00	648.00	197.21

Anthem Rates by Position
2011

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.24	537.92	268.96	14.16
		Empl + Child	1,472.48	1,398.86	699.43	36.81
		Empl + Spouse	1,546.08	1,468.78	734.39	38.65
		Family	2,078.23	1,974.31	987.16	51.96
	PPO	Single	632.62	600.98	300.49	15.82
		Empl + Child	1,644.85	1,562.61	781.31	41.12
		Empl + Spouse	1,726.53	1,640.21	820.11	43.16
		Family	2,321.72	2,205.64	1,102.82	58.04
	HSA	Single	479.01	455.05	227.53	11.98
		Empl + Child	1,245.46	1,183.18	591.59	31.14
		Empl + Spouse	1,307.74	1,242.36	621.18	32.69
		Family	1,758.03	1,670.13	835.07	43.95

2 Teacher/Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,546.08	1,530.62	765.31	7.73
		Family	2,078.23	2,057.45	1,028.72	10.39
	PPO	Empl + Spouse	1,726.53	1,709.26	854.63	8.63
		Family	2,321.72	2,298.50	1,149.25	11.61
	HSA	Empl + Spouse	1,307.74	1,294.66	647.33	6.54
		Family	1,758.03	1,740.45	870.22	8.79

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.24	329.92	164.96	118.16
		Empl + Child	1,472.48	702.49	351.25	385.00
		Empl + Spouse	1,546.08	730.28	365.14	407.90
		Family	2,078.23	951.06	475.53	563.59
	PPO	Single	632.62	329.92	164.96	151.35
		Empl + Child	1,644.85	702.49	351.25	471.18
		Empl + Spouse	1,726.53	730.28	365.14	498.13
		Family	2,321.72	951.06	475.53	685.33
	HSA	Single	479.01	329.92	164.96	74.55
		Empl + Child	1,245.46	702.49	351.25	271.49
		Empl + Spouse	1,307.74	730.28	365.14	288.73
		Family	1,758.03	951.06	475.53	403.49

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.24	164.96	82.48	200.64
		Empl + Child	1,472.48	351.25	175.62	560.62
		Empl + Spouse	1,546.08	365.14	182.57	590.47
		Family	2,078.23	475.53	237.77	801.35
	PPO	Single	632.62	164.96	82.48	233.83
		Empl + Child	1,644.85	351.25	175.62	646.80
		Empl + Spouse	1,726.53	365.14	182.57	680.70
		Family	2,321.72	475.53	237.77	923.10
	HSA	Single	479.01	164.96	82.48	157.03
		Empl + Child	1,245.46	351.25	175.62	447.11
		Empl + Spouse	1,307.74	365.14	182.57	471.30
		Family	1,758.03	475.53	237.77	641.25

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,546.08	967.54	483.77	289.27
		Family	2,078.23	1,174.31	587.16	451.96
	PPO	Empl + Spouse	1,726.53	967.54	483.77	379.50
		Family	2,321.72	1,174.31	587.16	573.71
	HSA	Empl + Spouse	1,307.74	967.54	483.77	170.10
		Family	1,758.03	1,174.31	587.16	291.86

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.24	375.00	187.50	95.62
		Empl + Child	1,472.48	498.00	249.00	487.24
		Empl + Spouse	1,546.08	498.00	249.00	524.04
		Family	2,078.23	498.00	249.00	790.12
	PPO	Single	632.62	375.00	187.50	128.81
		Empl + Child	1,644.85	498.00	249.00	573.43
		Empl + Spouse	1,726.53	498.00	249.00	614.27
		Family	2,321.72	498.00	249.00	911.86
	HSA	Single	479.01	375.00	187.50	52.01
		Empl + Child	1,245.46	498.00	249.00	373.73
		Empl + Spouse	1,307.74	498.00	249.00	404.87
		Family	1,758.03	498.00	249.00	630.02

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	679.49	450.00	225.00	114.74
		Empl + Child	1,766.98	597.60	298.80	584.69
		Empl + Spouse	1,855.30	597.60	298.80	628.85
		Family	2,493.88	597.60	298.80	948.14
	PPO	Single	759.14	450.00	225.00	154.57
		Empl + Child	1,973.82	597.60	298.80	688.11
		Empl + Spouse	2,071.84	597.60	298.80	737.12
		Family	2,786.06	597.60	298.80	1,094.23
	HSA	Single	574.81	450.00	225.00	62.41
		Empl + Child	1,494.55	597.60	298.80	448.48
		Empl + Spouse	1,569.29	597.60	298.80	485.84
		Family	2,109.64	597.60	298.80	756.02

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	679.49	450.00	225.00	114.74
		Empl + Child	1,766.98	597.60	298.80	584.69
		Empl + Spouse	1,855.30	597.60	298.80	628.85
		Family	2,493.88	597.60	298.80	948.14
	PPO	Single	759.14	450.00	225.00	154.57
		Empl + Child	1,973.82	597.60	298.80	688.11
		Empl + Spouse	2,071.84	597.60	298.80	737.12
		Family	2,786.06	597.60	298.80	1,094.23
	HSA	Single	574.81	450.00	225.00	62.41
		Empl + Child	1,494.55	597.60	298.80	448.48
		Empl + Spouse	1,569.29	597.60	298.80	485.84
		Family	2,109.64	597.60	298.80	756.02

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.24	375.00	187.50	95.62
		Empl + Child	1,472.48	607.00	303.50	432.74
		Empl + Spouse	1,546.08	607.00	303.50	469.54
		Family	2,078.23	664.00	332.00	707.12
	PPO	Single	632.62	375.00	187.50	128.81
		Empl + Child	1,644.85	607.00	303.50	518.93
		Empl + Spouse	1,726.53	607.00	303.50	559.77
		Family	2,321.72	664.00	332.00	828.86
	HSA	Single	479.01	375.00	187.50	52.01
		Empl + Child	1,245.46	607.00	303.50	319.23
		Empl + Spouse	1,307.74	607.00	303.50	350.37
		Family	1,758.03	664.00	332.00	547.02

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer *Grade Reporting Specialist	HMO	Single	566.24	375.00	187.50	95.62
		Empl + Child	1,472.48	607.00	303.50	432.74
		Empl + Spouse	1,546.08	607.00	303.50	469.54
		Family	2,078.23	664.00	332.00	707.12
	PPO	Single	632.62	375.00	187.50	128.81
		Empl + Child	1,644.85	607.00	303.50	518.93
		Empl + Spouse	1,726.53	607.00	303.50	559.77
		Family	2,321.72	664.00	332.00	828.86
	HSA	Single	479.01	375.00	187.50	52.01
		Empl + Child	1,245.46	607.00	303.50	319.23
		Empl + Spouse	1,307.74	607.00	303.50	350.37
		Family	1,758.03	664.00	332.00	547.02

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.24	378.00	189.00	94.12
		Empl + Child	1,472.48	452.00	226.00	510.24
		Empl + Spouse	1,546.08	452.00	226.00	547.04
		Family	2,078.23	452.00	226.00	813.12
	PPO	Single	632.62	378.00	189.00	127.31
		Empl + Child	1,644.85	452.00	226.00	596.43
		Empl + Spouse	1,726.53	452.00	226.00	637.27
		Family	2,321.72	452.00	226.00	934.86
	HSA	Single	479.01	378.00	189.00	50.51
		Empl + Child	1,245.46	452.00	226.00	396.73
		Empl + Spouse	1,307.74	452.00	226.00	427.87
		Family	1,758.03	452.00	226.00	653.02

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.24	328.00	164.00	119.12
		Empl + Child	1,472.48	412.00	206.00	530.24
		Empl + Spouse	1,546.08	412.00	206.00	567.04
		Family	2,078.23	412.00	206.00	833.12
	PPO	Single	632.62	328.00	164.00	152.31
		Empl + Child	1,644.85	412.00	206.00	616.43
		Empl + Spouse	1,726.53	412.00	206.00	657.27
		Family	2,321.72	412.00	206.00	954.86
	HSA	Single	479.01	328.00	164.00	75.51
		Empl + Child	1,245.46	412.00	206.00	416.73
		Empl + Spouse	1,307.74	412.00	206.00	447.87
		Family	1,758.03	412.00	206.00	673.02

Transportation Office Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	566.24	375.00	187.50	95.62
		Empl + Child	1,472.48	972.00	486.00	250.24
		Empl + Spouse	1,546.08	972.00	486.00	287.04
		Family	2,078.23	1,296.00	648.00	391.12
	PPO	Single	632.62	375.00	187.50	128.81
		Empl + Child	1,644.85	972.00	486.00	336.43
		Empl + Spouse	1,726.53	972.00	486.00	377.27
		Family	2,321.72	1,296.00	648.00	512.86
	HSA	Single	479.01	375.00	187.50	52.01
		Empl + Child	1,245.46	972.00	486.00	136.73
		Empl + Spouse	1,307.74	972.00	486.00	167.87
		Family	1,758.03	1,296.00	648.00	231.02

Anthem Rates By Position
December 15, 2011

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	513.59	462.23	231.12	25.68
		Empl + Child	1,335.55	1,202.00	601.00	66.78
		Empl + Spouse	1,402.31	1,262.08	631.04	70.12
		Family	1,884.98	1,696.48	848.24	94.25
	PPO	Single	573.79	516.41	258.21	28.69
		Empl + Child	1,491.90	1,342.71	671.36	74.60
		Empl + Spouse	1,565.98	1,409.38	704.69	78.30
		Family	2,105.82	1,895.24	947.62	105.29
	HSA	Single	434.47	391.02	195.51	21.72
		Empl + Child	1,129.64	1,016.68	508.34	56.48
		Empl + Spouse	1,186.13	1,067.52	533.76	59.31
		Family	1,594.55	1,435.10	717.55	79.73

2 Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,402.31	1,388.29	694.14	7.01
		Family	1,884.98	1,866.13	933.07	9.42
	PPO	Empl + Spouse	1,565.98	1,550.32	775.16	7.83
		Family	2,105.82	2,084.76	1,042.38	10.53
	HSA	Empl + Spouse	1,186.13	1,174.27	587.13	5.93
		Family	1,594.55	1,578.60	789.30	7.97

Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	513.59	311.44	155.72	101.08
		Empl + Child	1,335.55	663.15	331.58	336.20
		Empl + Spouse	1,402.31	689.38	344.69	356.47
		Family	1,884.98	897.80	448.90	493.59
	PPO	Single	573.79	311.44	155.72	131.18
		Empl + Child	1,491.90	663.15	331.58	414.38
		Empl + Spouse	1,565.98	689.38	344.69	438.30
		Family	2,105.82	897.80	448.90	604.01
	HSA	Single	434.47	311.44	155.72	61.52
		Empl + Child	1,129.64	663.15	331.58	233.25
		Empl + Spouse	1,186.13	689.38	344.69	248.38
		Family	1,594.55	897.80	448.90	348.38

Part-Time Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	513.59	155.72	77.86	178.94
		Empl + Child	1,335.55	331.58	165.79	501.99
		Empl + Spouse	1,402.31	344.69	172.35	528.81
		Family	1,884.98	448.90	224.45	718.04
	PPO	Single	573.79	155.72	77.86	209.04
		Empl + Child	1,491.90	331.58	165.79	580.16
		Empl + Spouse	1,565.98	344.69	172.35	610.65
		Family	2,105.82	448.90	224.45	828.46
	HSA	Single	434.47	155.72	77.86	139.38
		Empl + Child	1,129.64	331.58	165.79	399.03
		Empl + Spouse	1,186.13	344.69	172.35	420.72
		Family	1,594.55	448.90	224.45	572.83

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Empl + Spouse	1,402.31	913.36	456.68	244.48
		Family	1,884.98	1,108.55	554.28	388.22
	PPO	Empl + Spouse	1,565.98	913.36	456.68	326.31
		Family	2,105.82	1,108.55	554.28	498.64
	HSA	Empl + Spouse	1,186.13	913.36	456.68	136.39
		Family	1,594.55	1,108.55	554.28	243.00

Bus Aide	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	616.31	424.80	212.40	95.75
		Empl + Child	1,602.66	564.13	282.07	519.26
		Empl + Spouse	1,682.77	564.13	282.07	559.32
		Family	2,261.98	564.13	282.07	848.92
	PPO	Single	688.55	424.80	212.40	131.87
		Empl + Child	1,790.28	564.13	282.07	613.07
		Empl + Spouse	1,879.18	564.13	282.07	657.52
		Family	2,526.98	564.13	282.07	981.43
	HSA	Single	521.36	424.80	212.40	48.28
		Empl + Child	1,355.57	564.13	282.07	395.72
		Empl + Spouse	1,423.36	564.13	282.07	429.61
		Family	1,913.46	564.13	282.07	674.66

Bus Driver	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	616.31	424.80	212.40	95.75
		Empl + Child	1,602.66	564.13	282.07	519.26
		Empl + Spouse	1,682.77	564.13	282.07	559.32
		Family	2,261.98	564.13	282.07	848.92
	PPO	Single	688.55	424.80	212.40	131.87
		Empl + Child	1,790.28	564.13	282.07	613.07
		Empl + Spouse	1,879.18	564.13	282.07	657.52
		Family	2,526.98	564.13	282.07	981.43
	HSA	Single	521.36	424.80	212.40	48.28
		Empl + Child	1,355.57	564.13	282.07	395.72
		Empl + Spouse	1,423.36	564.13	282.07	429.61
		Family	1,913.46	564.13	282.07	674.66

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	513.59	354.00	177.00	79.80
		Empl + Child	1,335.55	573.01	286.51	381.27
		Empl + Spouse	1,402.31	573.01	286.51	414.65
		Family	1,884.98	626.82	313.41	629.08
	PPO	Single	573.79	354.00	177.00	109.90
		Empl + Child	1,491.90	573.01	286.51	459.45
		Empl + Spouse	1,565.98	573.01	286.51	496.49
		Family	2,105.82	626.82	313.41	739.50
	HSA	Single	434.47	354.00	177.00	40.24
		Empl + Child	1,129.64	573.01	286.51	278.32
		Empl + Spouse	1,186.13	573.01	286.51	306.56
		Family	1,594.55	626.82	313.41	483.87

Misc 260 Day Positions	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
*Technology Application Specialist *Production Printer *College Admissions Coordinator *Security Officer *Grade Reporting Specialist	HMO	Single	513.59	354.00	177.00	79.80
		Empl + Child	1,335.55	573.01	286.51	381.27
		Empl + Spouse	1,402.31	573.01	286.51	414.65
		Family	1,884.98	626.82	313.41	629.08
	PPO	Single	573.79	354.00	177.00	109.90
		Empl + Child	1,491.90	573.01	286.51	459.45
		Empl + Spouse	1,565.98	573.01	286.51	496.49
		Family	2,105.82	626.82	313.41	739.50
	HSA	Single	434.47	354.00	177.00	40.24
		Empl + Child	1,129.64	573.01	286.51	278.32
		Empl + Spouse	1,186.13	573.01	286.51	306.56
		Family	1,594.55	626.82	313.41	483.87

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	513.59	354.00	177.00	79.80
		Empl + Child	1,335.55	470.11	235.06	432.72
		Empl + Spouse	1,402.31	470.11	235.06	466.10
		Family	1,884.98	470.11	235.06	707.44
	PPO	Single	573.79	354.00	177.00	109.90
		Empl + Child	1,491.90	470.11	235.06	510.90
		Empl + Spouse	1,565.98	470.11	235.06	547.94
		Family	2,105.82	470.11	235.06	817.86
	HSA	Single	434.47	354.00	177.00	40.24
		Empl + Child	1,129.64	470.11	235.06	329.77
		Empl + Spouse	1,186.13	470.11	235.06	358.01
		Family	1,594.55	470.11	235.06	562.22

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	513.59	356.83	178.42	78.38
		Empl + Child	1,335.55	426.69	213.35	454.43
		Empl + Spouse	1,402.31	426.69	213.35	487.81
		Family	1,884.98	426.69	213.35	729.15
	PPO	Single	573.79	356.83	178.42	108.48
		Empl + Child	1,491.90	426.69	213.35	532.61
		Empl + Spouse	1,565.98	426.69	213.35	569.65
		Family	2,105.82	426.69	213.35	839.57
	HSA	Single	434.47	356.83	178.42	38.82
		Empl + Child	1,129.64	426.69	213.35	351.48
		Empl + Spouse	1,186.13	426.69	213.35	379.72
		Family	1,594.55	426.69	213.35	583.93

Cafeteria Worker	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	513.59	309.63	154.82	101.98
		Empl + Child	1,335.55	388.93	194.47	473.31
		Empl + Spouse	1,402.31	388.93	194.47	506.69
		Family	1,884.98	388.93	194.47	748.03
	PPO	Single	573.79	309.63	154.82	132.08
		Empl + Child	1,491.90	388.93	194.47	551.49
		Empl + Spouse	1,565.98	388.93	194.47	588.53
		Family	2,105.82	388.93	194.47	858.45
	HSA	Single	434.47	309.63	154.82	62.42
		Empl + Child	1,129.64	388.93	194.47	370.36
		Empl + Spouse	1,186.13	388.93	194.47	398.60
		Family	1,594.55	388.93	194.47	602.81

Transportation Office Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	HMO	Single	513.59	354.00	177.00	79.80
		Empl + Child	1,335.55	917.57	458.79	208.99
		Empl + Spouse	1,402.31	917.57	458.79	242.37
		Family	1,884.98	1,223.42	611.71	330.78
	PPO	Single	573.79	354.00	177.00	109.90
		Empl + Child	1,491.90	917.57	458.79	287.17
		Empl + Spouse	1,565.98	917.57	458.79	324.21
		Family	2,105.82	1,223.42	611.71	441.20
	HSA	Single	434.47	354.00	177.00	40.24
		Empl + Child	1,129.64	917.57	458.79	106.04
		Empl + Spouse	1,186.13	917.57	458.79	134.28
		Family	1,594.55	1,223.42	611.71	185.57