## Anthem.

### MSD OF WAYNE TOWNSHIP Blue Preferred<sup>®</sup> 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 <sup>1</sup>	\$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 <sup>1</sup> , pelvic exams and Pap tests, immunizations <sup>1</sup> , 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:	
Emerg∋ncy 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 <sup>2</sup>	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 <sup>3</sup>	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.

- 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.
- These covered services are covered in full if you have a flat dollar copayment and if rendered without an office visit.
- Mental health/substance abuse must be authorized by the mental health administrator for services to be covered.
   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. 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.

## Anthem.

### MSD OF WAYNE TOWNSHIP Blue Access<sup>SM</sup> (PPO) Summary of Benefits, Effective January 1, 2007

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESP	PONSIBILITY)
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-netwo	rk
Office Services     Including Allergy - testing and treatment     - serum and injections'	\$20 Network/30% Non-network Per Visit	
Preventive Care	\$20 Network/30% Non-network Per Visit. Included apply. Preventive care includes: medical history, m immunizations <sup>1</sup> , routine and annual diabetic eye ex	nammoorams! nelvic exams and Pan tests
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	e 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 <sup>2</sup>	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 <sup>3</sup>	Covered in full Network/50% Non-network (Does no	
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

- 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.
- These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.
- <sup>2</sup> Mental health/substance abuse must be authorized by the mental health administrator for services to be covered at the highest benefit level.
- <sup>3</sup> 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.
- 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 dateLate 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.

## Anthem.

### MSD of Wayne Township Blue Access<sup>SM</sup> 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	Single: <b>\$2</b> ,000 Family: <b>\$4</b> ,000	Single: \$4,000 Family: \$8,000
coinsurance applies. The single deductible <b>does not</b> apply to family coverage. (This only applies to non-embedded deductible designs)		
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)/Specially Care Physician (SCP)	0%	30%
<ul> <li>Including Office Surgeries and allergy serum, allergy injections and allergy testing</li> </ul>		
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)		
<ul> <li>Physician Home and Office Visits (PCP/SCP)</li> </ul>	No copayment/coinsurance	30%
<ul> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	No copayment/coinsurance	30%
Emergency and Urgent Care		
<ul> <li>Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted)</li> </ul>	0%	0%
Urgent Care Center Services	0%	0%
Inpatient and Outpatient Professional Services	0%	30%
Include but are not limited to.	0.76	50 %
<ul> <li>Medical Care visits (1 per day), Intensive Medical Care,</li> </ul>		
Concurrent Care, Consultations, Surgery and administration		
of general anesthesia and Newborn exams		
Inpatient Facility Services	0%	30%
Unlimited days except for:	}	
<ul> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy</li> </ul>		
Services on an outpatient basis)		
90 days Network/Non-Network combined for skilled nursing facility		
Dutpatient Surgery Hospital/Alternative Care Facility Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services (including but not limited to):	0%	30%
Non Surgical Oulpatient 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		
\$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)		
\$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) Prosthetic Devices \$4,000 benefit maximum		
\$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)	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	0% 0%	30% 30%
<ul> <li>Manipulation therapy: 20 visits</li> <li>Speech therapy: 20 visits</li> </ul>		
Behavioral Health Services: Mental Health and Substance Abuse <sup>1</sup> (limits and maximums apply)		
<ul> <li>Inpatient Facility Services</li> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	0% 0% 0%	30% 30% 30%
<ul> <li>Human Organ and Tissue Transplants</li> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	0%	30%
Prescription Drugs Network Tier structure equals 1/2/3 (and 4, if applicable) • Network Retail Pharmacies:	0%	30%2
(30-day supply) Includes diabetic test strip		
Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip	0%	Not covered
Lifetime Maximum (Combined Network and Non-network) <sup>3</sup> Medical	\$5 million	\$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Not covered	Not covered

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

<sup>4</sup> Benefit period – catchian year <sup>1</sup>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.

<sup>2</sup> non-network diabetic/asthmatic supplies not covered except diabetic test strips.
<sup>3</sup> 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

## Anthem.

### MSD of Wayne Township Blue Preferred<sup>®</sup> 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)	\$35
Primary Care Physician (PCP)/Specially Care Physician (SCP)	
Including Office Surgeries and allergy serum:	
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)
<ul> <li>routine and non-routine mammograms (regardless of outpatient setting)</li> </ul>	\$35
<ul> <li>diabetic education (regardless of outpatient setting)</li> <li>diabetic education (regardless of outpatient setting)</li> </ul>	005
<ul> <li>certain medical nutritional therapy (regardless of outpatient setting)</li> </ul>	\$35
certain incluear humaniar merapy (regardiess of outpatient setting)	\$35
Preventive Care Services	
Services include but are not limited to:	
Routine E cams, Pelvic Exams, Pap testing, PSA tests, Immunizations <sup>1</sup> ,	
Annual diabelic eye exam, Routine Vision and Hearing exams	
<ul> <li>Physician Home and Office Visits (PCP/SCP)</li> </ul>	\$35
Other Outpatient Services @ Hospital/Alternative Care Facility	\$150
Emergency and Urgent Care	
Emergency Room Services @ Hospital (facility/other covered services)	\$100
(copayment waived if admitted)	
Urgent Care Center Services	\$50
Inpatient and Outpatient Professional Services	No copayment/coinsurance
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	
Inpatient Facility Services	
Unlimited days except for:	\$500
<ul> <li>Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> </ul>	
Unlimited days for skilled nursing facility	
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	20%
Unlimited visits (excludes IV Therapy)	
Durable Medical Equipment and Orthotics	20%
Unlimited benefit maximum (excluding Prosthetic Devices and Medical Supplies)	
Prostivetic Devices Unlimited benefit maximum	20%
Physical Medicine Therapy Day Rehabilitation programs	\$150
Hospice Care     Ambulance Capital	No copayment/coinsurance
Ambulance Services	No copayment/coinsurance

Covered Benefits	Network
Outpatient Therapy Services (limits apply)	
Physician Home and Office Visits (PCP/SCP)	\$35
Other Outpatient Services @ Hospital/Alternative Care Facility	
Limits apply to:	
Physical therapy/Occupational therapy: 60 visits     Manipulation therapy: 10 visits	
Manipulation therapy: 12 visits     Speech therapy: 20 visits	
Speech therapy: 20 visits Behavioral Health Services:	
Mental Health and Substance Abuse <sup>2</sup>	
(limits and maximums apply)	
Inpatient Facility Services	¢500
Physician Home and Office Visits (PCP/SCP)	\$500
Outpatient Services @ Hospital/Alternative Care Facility	\$35
	\$150
Human Organ and Tissue Transplants <sup>3</sup>	No copayment/coinsurance
<ul> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	
Prescription Drugs Network	
Tier structure equals 1/2/3 (and 4, if applicable)	
Network Retail Pharmacies:	\$20/\$40/\$80
(30-day supply) Includes diabetic test strip	
Anthem Rx Direct Mail Service:	\$40/\$80/\$160
(90-day supply)	
Includes diabetic test strip	
Medicare Rx - Wrap	
Specialty Medications must be obtained via our Specialty Pharmacy network.	
Lifetime Maximum <sup>4</sup>	
Medical	\$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Unlimited

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 (a) Hospital where a percentage (%) constructed services taken with a percentage (so constructed to the construc

Physician systems in the dra once was copayment and appress of the once with the asymptotic on surface and once No copaymenticoinsurance 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 specially 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

These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

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.

Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

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.

## Anthem.

### MSD of Wayne Township Blue Access<sup>SM</sup> (PPO) Summary of Benefits, Effective January 1, 2008

COVERED BENEFITS	NETWORKINON-NETWORK (MEMBER'S RESPO	ONSIBILITY)
Deductible (Single/Family) (Applies only to percent (%) copeyments)	\$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 <ul> <li>Including Allergy – testing and treatment</li> <li>– serum and injections<sup>1</sup></li> </ul>	\$35 Network/40% Non-network Per Visit	
Preventive Care	\$35 Network/40% Non-network Per Visit. Included w apply. Preventive care includes: medical history, ma immunizations <sup>1</sup> , routine and annual diabetic eye exa	anmourams <sup>1</sup> nelvic exams and Pan tosts
Matemity 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 <sup>2</sup>	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 <sup>3</sup>	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

- 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.
- These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.
- 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.
- <sup>3</sup> 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.
- <sup>4</sup> 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 preexisting 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.

## Anthem.

### MSD of Wayne Township Blue Access<sup>SM</sup> for Health Savings Accounts Option H6 Summary of Benefits, Effective January 1, 2008

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	Single: \$2,000	Single: \$4,000
Family coverage requires the family deductible to be met before	Family: \$4,000	Family: \$8,000
coinsurance applies. The single deductible does not apply to family		
coverage.		
(This only applies to non-embedded deductible designs)		
Out-of-Pocket Light (Single/Famiry)	Sing'e: \$2,000 Family: <b>\$</b> 4,000	Single: \$8,000 Family: \$16,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP)	0%	30%
<ul> <li>Including Office Surgeries and allergy serum, allergy injections and allergy testing</li> </ul>		
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)	No copayment/coinsurance	30%
Other OL patient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	30%
Emergency and Urgent Care		
Emergency Room Services @ Hospital	0%	0%
(facility/other covered services)	0,00	0.0
(copayment waived if admitted)		
Urgent Care Center Services	0%	0%
Inpatient and Outpatient Professional Services	0%	30%
Include but are not limited to:		
<ul> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>		
Inpatient Facility Services	0%	30%
Unlimited days exception:		
<ul> <li>60 days Network/Non-Network combined for physical</li> </ul>		
medicine/rehab (limit includes Day Rehabilitation Therapy		
Services on an outpatient basis)		
<ul> <li>S0 days Network/Non-Network combined for skilled nursing facility</li> </ul>		
Dutpatient Surgery Hospital/Alternative Care Facility	0%	30%
Surgery and administration of general anesthesia		
Other Outpatient Services (including but not limited to):	0%	30%
Non Surgical Outpatient Services		
For example: MRIs, C-Scans, Chemotherapy, Ultrasounds		
and other diagnostic outpatient services.		
Home Care Services (Network/Non-network combined)		1
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	0%	0%
Ambulance Services	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 <sup>1</sup> Inpatient Facility Services Physician Home and Office Visite (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility	0%	30%
	0% 0%	30% 30%
Human Organ and Tissue Transplants	0%	30%
<ul> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>		0070
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 Rc - Wrap	0%	Not covered
Lifetime Maximum (Combined Network and Non-network) <sup>3</sup>		
Medical	\$5 million	\$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Not covered	Not covered

All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).

All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Hissue Franspianis). Deductible(5) 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 to 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 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, appending interval medicine, pediatrics, obstetrics/symecology, geriatrics or 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 Nenvork 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

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.

Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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 henefits 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 enroliment 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 us 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.

## Anthem. 🗣 🕅

### MSD of Wayne Township Blue Preferred<sup>®</sup> Primary (HMO) Summary of Benefits, Effective January 1, 2009

Covered Benefits	A at the Contract Natural
Deductible (Single/Family)	\$250/\$500
Out-of-Pocke: Limit (Single/Family)	\$3,000/\$6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP)	\$35
Including Office Surgeries and allergy serum:	
allergy injections (PCP and SCP)	
allergy testing	No copayment/coinsurance (if billed with office visit copay, then copay applies) No copayment/coinsurance (if billed with office visit copay, then copay applies)
routine and non-routine mammograms	\$35
(regardless of outpatient setting)	¥00
<ul> <li>diabetic education (regardless of outpatient setting)</li> </ul>	\$35
certain medical nutritional therapy (regardless of outpatient setting)	\$35
Preventive Care Services	
Services include but are not limited to:	
Routine Exams, Polyio Exams, Pap tasting, PSA tests, Immunizations1,	
Annual diabetic eye exam, Routine Vision and Hearing exams	
Physician Home and Office Visits (PCP/SCP)     Other Outpatient Services @ Unerstandard Constant Service	\$35
Other Outpatient Services @ Hospital/Alternative Care Facility	\$150
Emergency and Urgent Care	
<ul> <li>Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted)</li> </ul>	\$100
Urgent Care Center Services	\$50
Inpatient and Outpatient Professional Services	No copayment/coinsurance
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 exercis	
Inpatient Facility Services	\$500
Unlimited days except for:	
<ul> <li>Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> </ul>	
<ul> <li>Unlimited days for skilled nursing facility</li> </ul>	
Outpatient Surgery Hospital/Alternative Care Facility	\$250
Surgery and administration of general anesthesia	
Other Outpatient Services (including out not limited to):	\$150
Non-Surgical Outpatient Services	
For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and	ſ
other diagnostic outpatient services. (regardless of place of service)	200/
Home Care: Services     Unlimited visits (excludes IV Therapy)	20%
Durable Medical Equipment and Orthotics	20%
Unlimited benefit maximum (excluding Prosthetic Devices and Medical Supplies)	
Prosthetic Devices Unlimited benefit maximum	20%
<ul> <li>Physical Medicine Therapy Day Rehabilitation programs</li> </ul>	\$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)	\$35
Other Outpatient Services @ Hospital/Alternative Care Facility	
Limits apply to:	
Physical therapy/Occupational therapy: 60 visits	
Manipulation therapy: 12 visits	
Speech therapy: 20 visits	
Behavioral Health Services:	
Mental Health and Substance Abuse <sup>2</sup> (limits and maximums apply)	
<ul> <li>Inpation Filling Science</li> </ul>	4600
Physician Home and Office Visits (PCP/SCP)	\$35
Outpatient Services @ Hospital/Alternative Care Facility	\$150
Human Organ and Tissue Transplants <sup>3</sup>	No copayment/coinsurance
<ul> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	
Prescription Drugs Network	
Tier structure equals 1/2/3 (and 4, if applicable)	
Network Retail Pharmacies:	
(30-day supply)	\$20/\$40/\$80
Diabetic Test Strip	No copayment/coinsurance
Anthem Rx Direct Mail Service:	\$40/\$80/\$160
(90-day suppiy)	
Diabetic Test Strip	No copayment/coinsurance
Medicare Rx - Wrap	
Specialty Medications must be obtained via our Specialty Pharmacy network.	
Lifetime Maximum <sup>1</sup>	
Medical	\$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Unlimited

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.

Prospiral where a percentage (26) constraince applies to other covere a services. Dependem 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 consurance means no deductible/copayment/consurance 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 cllowed 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 dial-tic 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

These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

<sup>2</sup>We encourage: 29 to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits

for limitations. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

<sup>4</sup>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.

## Anthem.

### MSD of Wayne Township Blue Access<sup>™</sup> (PPO) Summary of Benefits, Effective January 1, 2009

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPON	SIBILITY)
Deduct.blr. (Single/Family) (Applies only to percent (%) copayments)	\$500/\$1,000 Network/\$1,000/\$2,000 Non-network	
Out-of-Pockes Marimum (Single/Femily)	\$2,000/\$4,000 Network/\$4,000/\$8,000 Non-network	
Office Services	\$35 Network/40% Non-network Per Visit	
<ul> <li>Including Allergy – testing and treatment – serum and injections<sup>1</sup></li> </ul>		
Preventive Care	\$35 Network/40% Non-network Per Visit. Included with apply. Preventive care includes: medical history, mam immunizations <sup>1</sup> , routine and annual diabetic eye exam	mograms <sup>1</sup> , pelvic exams and Pap tests,
Maternity Services	20% Network/40% Non-network	
Inpatient Services	20% Network/40% Non-network per admission	
Outpasent Facility Services	20% Network/46% 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 of	copay as office services
Spinel Manipulation	12 Network and Non-network combined visits; same c	copay as office services
Speech	20 Network and Non-network combined visits; same c	copay as office services
Mental Health and Substance Abuse <sup>2</sup>	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 <sup>3</sup>	Covered in full Network/50% Non-network (Does not c	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

- 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.
- These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- <sup>4</sup> 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.

## Anthem. 🕾 🕅

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

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	Single: \$2,000	Single: \$4,000
Family coverage requires the family deductible to be met before	Family: \$4,000	Family: \$8,000
coinsurance applies. The single deductible does not apply to family		
coverage.		
(This only applies to non-embedded deductible designs)		
Out-of-Pocker Limit (Single/Family)	Single: \$2,000 Family: \$4,000	Single: \$8,000 Family: \$16,000
Physician Horne and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP)	0%	30%
<ul> <li>Including Office Surgeries and allergy serum, allergy injections and allergy testing</li> </ul>		
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)	No copayment/coinsurance	30%
Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	30%
Emergency and Urgent Care		
<ul> <li>Emergency Room Services @ Hcspital (facility/other covered services) (copayment waived if admitted)</li> </ul>	0%	0%
Urgent Gara Center Services	0%	0%
Inpatient and Outpatient Professional Services	0%	30%
Include but are not limited to:		
<ul> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>		
Inpatient Facility Services	0%	30%
Unlimited days except for:	070	50%
<ul> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> </ul>		
<ul> <li>90 days Network/Non-Network combined for skilled nursing facility</li> </ul>		
Outpatiant Surgery Hospital/Alternative Care Facility	0%	30%
Surgery and administration of general anesthesia	1' 070	30%
	0%	30%
Other Outpatient Services (including but not limited to):	0./0	0/ 00
Non Surgical Outpatient Services     For example: MRIs, C-Scans, Chemotherapy, Ultrasounds		
and other diagnostic outpatient services.		
<ul> <li>Home Care Services (Network/Non-network combined)</li> </ul>		
90 visits (excludes IV Therapy)		
<ul> <li>Durable Medical Equipment and Orthotics</li> </ul>		
(Network/Non-network combined)		
\$4,000 benefit maximum (excluding Prosthetic Devices and		
Medical Supplies) Prosthetic Daviass \$4,000 hensiit maximum		
Prosthetic Devices \$4,000 benefit maximum     Physical Madicine Therapy Day Rehabilitation programs		
<ul> <li>Hospice Care</li> </ul>	0%	0%
Ambulance Services	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	0% 0%	30% 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 <sup>1</sup> Inpatient Facility Services		
<ul> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	0% 0% 0%	30% 30% 30%
Human Organ and Tissue Transplants	0%	30%
<ul> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>		
Prescription Errugs		
<ul> <li>Network Tier structure equals 1/2/3 (and 4, if applicable)</li> <li>Network Retail Pharmacies: (30-day supply) Includes diapetic test strip</li> </ul>	0%	30%²
Anthem Rid Direct Mail Service: (90-day supply) Includes diabetic test strip Medicare Rx - Wrap	0%	Not covered
Lifetime Maximum (Combined Network and Non-network) <sup>3</sup>		
Medical	\$5 million	\$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical life) me maximum)	Not covered	Not covered

All deductions and consurance 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 cope to the consumer means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount He vever, 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 ostimatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.

Benefii period = calendar year

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

<sup>2</sup>Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

<sup>3</sup>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 Listusian Periods

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 eading 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.

.

## 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)	\$35
Industring Office Surgeries and allergy serum:	
allergy injections (PCP and SCP)     allergy testing	No copayment/coinsurance (if billed with office visit copay, then copay applies) No copayment/coinsurance (if billed with office visit copay, then copay applies)
<ul> <li>routine and non-routine mammograms</li> </ul>	\$35
(regardless of outpatient setting)	
<ul> <li>diabetic education (regardless of outpatient setting)</li> </ul>	\$35
<ul> <li>certain medical nutritional therapy (regardless of outpatient setting)</li> </ul>	\$35
Preventive Care Services	
Services include but are not limited to:	
Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations <sup>1</sup> ,	
Annual diabelic eye exam. Routine Vision and Hearing exams	acr.
Physician Home and Office Visits (PCP/SCP)	\$35
Other Outpatient Services @ Hospital/Alternative Care Facility Emergency and Urgent Care	\$150
Emergency and organicate     Emergency Room Services @ Hospital (facility/other covered services)	\$100
(copayment waived if admitted)	9100
Urgent Care Center Services	\$50
Inpatient and Outpatient Professional Services	No copayment/coinsurance
Include but are not limited to:	
<ul> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>	
Inpatient Facility Services	°500
Unlimited days except for	\$500
<ul> <li>Unimited data for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> </ul>	
<ul> <li>Unlimited days for skilled nursing facility</li> </ul>	
Outpatient Surgery Hospital/Alternative Care Facility	\$250
Surgery and administration of general anesthesia	
Other Outpatient Services (including but not limited to):	\$150
Non-Surgical Oulpatient Services	
For exemple: MRIs, C-Scans, Chemotherapy, Ultrasounds and	
<ul> <li>other diagnostic outpatient services. (regardless of place of service)</li> <li>Home Care Services</li> </ul>	20%
Home care services     Unlimited visits (excludes IV Therapy)	20 /3
Durable Medical Equipment and Orthotics	20%
Unlimited benefit maximum (excluding Prosthetic Devices and Medical Supplies)	
<ul> <li>Prosthetic Devices Unlimited benefit maximum</li> </ul>	20%
Physical Medicine Therapy Day Rehabilitation programs	\$150
Hospice Care     Section 2	No copayment/coinsurance
Ambulance Services	No copayment/coinsurance

Covered Benefits	
Outpatient Therapy Services (limits apply)	Network
Physician Home and Office Visits (PCP/SCP)	\$35
Other Outpatient Services @ Hospital/Alternative Care Facility	\$00
Limits apply to:	
Physical therapy/Occupational therapy: 60 visits	
Manipulation therapy: 12 visits	
Speech therapy: 20 visits	
Behavioral Health Services:	
Mental Health and Substance Abuse <sup>2</sup> (limits and maximums apply)	
Inpatient Facility Services	\$500
Physician Home and Office Visits (PCP/SCP)	\$35
<ul> <li>Outpatiunt Services @ ricegita/Alientietive Care Facility</li> </ul>	\$150
Human Organ and Tissue Transplants <sup>3</sup>	No copayment/coinsurance
<ul> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	
Prescription Drugs Network	
Tier structure equals 1/2/3 (and 4, if applicable)	
Network Retail Pharmacies:	
(30-day supply)	\$20/\$40/\$80/\$80
Diabetic Test Strip	No copayment/coinsurance
Anthem Rx Direct Mail Service:	
(10 day supply)	\$40/\$80/\$160/\$160
Diabetic Test Strip	No copayment/coinsurance
Medicare Rx - Wrap	
Specialty Medications must be obtained via our Specialty Pharmacy network.	
Lifetime Maximum <sup>4</sup>	
Medical	\$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Unlimited

Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.

Description Day only to covered medical services listed with a percentage (%) consurce. However, the deductible does not apply to Emergency Room Services @ Princible(s) apply only to covered medical services listed with a percentage (%) consumerce. However, the deductible does not apply to Emergency Room Services @ Pristed where a percentage (%) consumance applies to other covered services.

- Dependent age: to the end of extendar year; which the child attains age 24

- Dependent age: to the end of cuendar year; which the chila attains age 24 Prosteams Hane and office visu copariment also applies if the office visit is billed with all-ray injections. No copyriment/coinsurance means no deductible/copyriment/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-Gabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test surips.
- Berefit / cripd = calendar year
- These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

We encourage you to contact Our Mental Health Subcontructor to assure the use of appropricte procedures, setting and medical necessity. Refer to Schedule of Benefits The consideration of the contract our opening of the second subject to the medical benefits. Fulnes and Cornea are treated the same as any other illness and subject to the medical benefits. Prescription Drugs do not accumulate toward the Medical Lifetime Maximum, However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims Prescription Drugs do not accumulate toward the Medical Lifetime Maximum, However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims

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 cantained 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.

## Anthem 🚭 🗑

### MSD of Wayne Township Blue Access<sup>SM</sup> (PPO) Summary of Benefits, Effective January 1, 2010

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPO	NSIBILITY)
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	\$35 Network/40% Non-network Per Visit	
Including Allergy – testing and treatment     serum and injections <sup>1</sup>		
Preventive Care	\$35 Network/40% Non-network Per Visit. Included wi apply. Preventive care includes. medical history, man immunizations <sup>1</sup> , routine and annual diabetic eye exar	nmograms <sup>1</sup> , pelvic exams and Pap tests.
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 il 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 c	copay as office services
Spinal Manipulation	12 Network and Non-network combined visits; same c	
Speech	20 Network and Non-network combined visits; same c	
Mental Health and Substance Abuse?	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 <sup>3</sup>	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

- 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 pharmacics.
- Office services also includes office surgeries and preconception care/education.
- <sup>1</sup> These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- 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.

## Anthem.

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

Deductible (Single/Family)         Single \$2,000         Single \$4,000           Family Coverage requires the family diductible does not apply to family (Wargap)         Family S4,000         Family: \$8,000           (This only applies to non-mobe/ded deductible designs)         Single \$2,000         Family: \$8,000           Out-of-Pocket Limit (Single/Family)         Franky: \$8,000         Family: \$10,000           Physician Home and Office Services (PCP/SCP)         0%         30%           Privary Care Physician (PCP) Special (Care Physician (SCP)         0%         30%           • Including Office Surgines and allegy serum, allergy injections and allegy serum, allergy injections and allegy serum, allergy injections and allergy tesm, Annual discle (PCP/SCP)         No copayment/coinsurance         30%           Preventive Care Services         Services include and are on timined to:         No copayment/coinsurance         30%           Routine Exams, Pakic Exams, Pao testing, PSA tests, Immunizations, Annual diabetic preventives (are Facility         No copayment/coinsurance         30%           Emergency Room Services (a) Hospital (facility/differ and the differ Poilse (Pask) (PCP/SCP)         No copayment/coinsurance         30%           Unget Care Covered services         0%         0%         0%         0%           Unget Care Covered services         0%         0%         30%         0%           Unget Care Covered	Covered Benefits	Network	Non-Network
coinsurance applies     The single ideductible does not apply to family crystrage.     Single \$2,000     Single \$3,000       Cut-of-Pocket Limit (SingleFamily)     Single \$2,000     Family: \$4,000     Single \$3,000       Physician Home and Office Services (PCP)SCP)     0%     30%       Privator Care Physican (PCP)Special (Care Prysician (SCP) • Including Office Surgeries and allergy serum, allergy injections and allergy testing     0%     30%       Preventive Care Services     Services include but are not imited to: Routine Exams, Petic Exams, Pap testing, PSA tests, Innumizations, Annuel diabetic eyes eam, Annuel Vision and Hearing exams, Routine Marninggrams, Diabetic Education and Certain Medical Nutritional Therapy (Network onty)     No copayment/coinsurance     30%       • Dimergency and Urgent Care • Comparent Covered services (Hospital (facility/other Covered services) (copayment wavefil a dimited)     0%     0%       • Urgent Care Center Services (copayment wavefil a dimited)     0%     30%       • Urgent Care Center Services (copayment wavefil a dimited)     0%     30%       • Urgent Care Center Services (copayment wavefil a dimited)     0%     30%       • Urgent Care Center Services (copayment wavefil a dimited)     0%     30%       • Urgent Care Center Services (copayment wavefil a dimited)     0%     30%       • Urgent Care Center Services (consumm Care Consultations: Surgery and admiteration of general anesthesia and Newborn exams     0%     30%       • Modical Care visits (1 per day)	Deductible (Single/Family)	Single: \$2,000	Single: \$4,000
(This Gity) applies to non-embedded deductible designs)     Single 52.000     Single 52.000       Physician Home and Office Services (PCP/SCP)     Physician Home and Office Services (PCP/SCP)     0%       Physician Home and Office Services (PCP/SCP)     0%     30%       Preventive Care Services     Services include but are not limited to:     0%       Roulne Exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only)     No copayment/coinsurance     30%       - Physician Home and Office Vise (B Hospital/Alternative Care Facility     0%     0%     0%       - Emergency And Urgent Care     0%     0%     0%       - Emergency Room Services (B Hospital/Alternative Care Facility     0%     0%     0%       - Ungent Care Center Services     0%     0%     0%       - Medical Care visits (1 per day). Intensive Medical Care. Concurrent Corpatients Neuroles and Network combined for physical medicine/enable filter Services     0%     0%       - 50 days Network/Non-Network combined for physical medicine/enable filter Services (Includie but not filter tor)     0%     30%       - 50 days Network/Non-Network combined for physical medicine/enable filter Liculdes Day Rehabilitation Therapy Services on a outpatient Professional Services     0%     30%       - 50 days Network/Non-Network combined for skilled nursing facility     0%     30%       - 50 days Network/Non-Network combined for physical medicine/enable filter Liculdes Day	coinsurance applies. The single deductible does not apply to family	r anniy. 94,000	1 bring: \$0,000
Family:         St.000         Family:         St.000           Physician Home and Office Services (PCP/SCP)         Privary Care Physician (FCP/Spceally Care Physician (SCP)         0%         30%           Including:         Office Surgeries and allergy serum, allergy injections and allergy lesing         0%         30%           Preventive Care Services         Services include but are not limited to:         No copayment/coinsurance         30%           Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diseling exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only)         No copayment/coinsurance         30%           Other Outgatient Services (@ Hospital/Attenative Care Facility         No copayment/coinsurance         30%           Emergency and Urgent Care         0%         0%         0%           Inpatient and Outgatient Professional Services         0%         0%         0%           Inpatient and Outgatient Professional Services         0%         0%         30%           Inpatient and Outgatient Professional Services         0%         0%         30%           Inpatient and Outgatient Professional Services         0%         0%         30%           Inpatient Acitity Services         0%         0%         30%           Inducted days except for:         60 days NetworkNon-Network combined fo			
Primary Care Physician (PCP)Specially Care Physician (SCP)         Including Office Surgeries and alergy serum, alergy njections and alergy testing           Preventive Care Services Services include but are not limited to:         Services include but are not limited to:           Routine Exams, Petvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Annual Vision and Hearing exams, Routine Mannograms, Dubetic Education and Certain Medical Nutritional Therapy (Network only)         No copayment/coinsurance         30%           • Other Outpatient Services @ Hospital/Atternative Care Facility         No copayment/coinsurance         30%           • Emergency Room Services @ Hospital (tacility/other covered services) (copayment wave if admitted)         0%         0%           • Urgent Care Center Services         0%         0%         0%           Inpatient and Outpatient Professional Services (concurrent Care, Consultanted)         0%         0%           • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultanted bit are not limited to:         0%         30%           • Madical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultanted bit for skilled nursing facility         0%         30%           • Urgent Care Care facility         0%         30%         0%         30%           • Dubate bit are not limited to:         0%         30%         0%         30%           Inpatient Tacility Services <td< td=""><td>Out-of-Pocket Limit (Single/Family)</td><td></td><td></td></td<>	Out-of-Pocket Limit (Single/Family)		
and allergy testing	Primary Care Physician (PCP)/Specialty Care Physician (SCP)	0%	30%
Services include but are not limited to:     Routine Exams, Petvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic get exam, Annual Vision and Hearing exams, Routine Mammograms, Diabetic Education and Certain Medical reapy (Network only)     No coparyment/coinsurance     30%       Cher Outpatient Services (B Hospital/Atternative Care Facility     No coparyment/coinsurance     30%       Emergency and Urgent Care     0%     0%       Impatient and Ottrace Services (D Hospital (Coparyment waived if admitted)     0%     0%       Urgent Care Center Services     0%     0%       Inductional Therefore Services (D Hospital (Coparyment waived if admitted)     0%     0%       Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams impatient Facility Services     0%     30%       Unlimited days except for:     0%     0%     30%       • 60 days Network/Non-Network combined for physical medicine/Fifty Services (Includes Day Rehabilitation Therapy Services (Includes Day Rehabilitation Therapy Services (Includes Care Facility     0%     30%       Outpatient Services (Including but not limited to):     0%     30%     30%       Non Surgical Outpatient Foreices     0%     30%     30%       Outpatient Services (Including but not limited to):     0%     30%       Non Surgical Outpatient Services     0%     30%       For example, MRIs, C-Scans, Chemotherapy, U			
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)     30%          Physician Home and Office Visits (PCPSCP) • Other Outpatient Services @ Hospital/Itemative Care Facility • Emergency and Urgent Care • Emergency Room Services @ Hospital/Itemative Care Facility • Urgent Care Center Services (copayment/coinsurance 10%       0%       0%         • Urgent Care Center Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Consultations, Surgery and administration of general anesthesia and Newborn exams Inpatient Facility Services Unimited 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 • Surgery and administration of general anesthesia Offic       0%       30%         Other Outpatient Services (Including but not limited to): • Non Surgical Outpatient Services, Cherubertexpy, Ultrasounds for example MRIS, C-Scans, Cherubertexp, Ultrasounds for example MRIS, C-Scans, Cherubertexpy, Ultrasounds for example MRIS, C-Scans, Cherubertexpy, Ultrasounds for example MRIS, C-Scans, Cherubertexp, Ultrasounds for example MRIS, C-Scans, Cherubertexp, Ultrasounds for example MRIS, C-Scans, Cheruberexp, Ultrasounds for example MRIS, C-Scans, Cheruber	Preventive Care Services		
Immunizations, Annual diabetic eye exam, Annual Vision and Hearing exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only)       No copayment/coinsurance       30% <ul> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>No copayment/coinsurance</li> <li>Chergency and Urgent Care</li> <li>Emergency and Urgent Care</li> <li>Imagine Services @ Hospital/Atternative Care Facility</li> <li>No copayment/coinsurance</li> <li>30%</li> <li>O%</li> <li>O%</li></ul>	Services include but are not limited to:		
and Hearing exams, Routine Marimograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only) Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Emergency Room Services @ Hospital (facility/Other covered services) (copayment waived if admitted) - Urgent Care Center Services (copayment waived if admitted) - Urgent Care Center Services (copayment waived if admitted) - Urgent Care Center Services (concurrent on timiled to: - Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and admitistation of general anesthesia and Newborn exams Impatient Facility Services Office Outpatient Services - 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy - Surgery and admitistration of general anesthesia Other Outpatient Services - Surgery and admitistration of general anesthesia Other Outpatient Services - Surgery and admitistration of general anesthesia Other Outpatient Services - Surgery and admitistration of general anesthesia Other Outpatient Services (including but not limited to) - Non Surgical Outpatient Services - Home Care Services (Network/Non-network combined) 90 visit (seculdes IV Therapy) - Durable Medical Carephy Day Rehabilitation programs - Home Care Services (Network/Non-network combined) 90 visit (seculdes IV Therapy) - Durable Medical Equipment and Orthotics (Network/Non-network combined) 90 visit (seculdes IV Therapy) - Durable Medical Equipment and Orthotics (Network/Non-network combined) 90 visit (seculdes IV Therapy) - Durable Medical Equipment and Orthotics - Home Care Services \$4,000 benefit maximum - Physical Medicine Therapy Day Rehabilitation programs - Hospice Care			
Certain Medical Nutritional Therapy (Network only)       No copayment/coinsurance       30%         • Other Outpatient Services @ Hospital/Alternative Care Facility       No copayment/coinsurance       30%         Emergency Room Services @ Hospital/Alternative Care Facility       0%       0%         Impatient and Outpatient Services       0%       0%         Impatient and Outpatient Professional Services       0%       0%         Indical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams       0%       30%         Inpatient and outpatient Professional Services       0%       30%       0%         Inpatient facility Services       0%       30%       0%         Unimeted days except for:       0%       30%       0%         • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%       30%         • 90 days Network/Non-Network combined for skilled nursing facility       0%       30%       30%         Other Outpatient Services (including but not limited to):       0%       30%       30%         • 90 days Network/Non-Network combined for skilled nursing facility       0%       30%       30%         • 90 days Network/Non-Network combined for skilled nursing facility       0% <td></td> <td></td> <td></td>			
Physician Home and Office Visits (PCP/SCP)     No copayment/coinsurance     30%     0%			
Other Outpatient Services @ Hospital/Alternative Care Facility       No copayment/coinsurance       30%         Emergency and Urgent Care       0%       0%         Image of the covered services () (copayment waved if admitted)       0%       0%         Urgent Care Center Services       0%       0%         Inpatient and Outpatient Professional Services       0%       0%         Include but are not limited to:       0%       0%         • Medical Care visits (1 per day). Intensive Medical Care. Concurrent Care, Consultations. Surgery and administration of general anesthesia and Newborn exams       0%       30%         Impatient Facility Services       0%       30%       0%         Unlimited days except for:       0%       30%       0%         Services on an outpatient basis)       0%       30%       0%         Outpatient Services (including but not limited to:       0%       30%         Outpatient Services (including but not limited to:       0%       30%         Outpatient Services (including but not limited to:):       0%       30%         Outpatient Services (including but not limited to:):       0%       30%         Other Outpatient Services (including but not limited to:):       0%       30%         Non Surgical Outpatient Services (including but not limited to:):       0%       30%		No consumpationingurance	30%
Dis Dependent Control of the Contr			
Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted)     Urgent Care Center Services     0%		No copayment/consurance	
(tacility/other covered services) (copayment waived if admitted)       0%       0%         Urgent Care Center Services       0%       0%         Inplatient and Outpatient Professional Services       0%       30%         Include but are not limited to:       0%       30%         • 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       0%       30%         Unlimited days except for:       0%       30%         • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%       30%         • 90 days Network/Non-Network combined for skilled nursing facility       0%       30%         • Surgery and administration of general anesthesia       0%       30%         Other Outpatient Services (including but not limited to): • Non Surgical Outpatient Services, Chemotherapy, Ultrasounds and other diagnostic outpatient Services, Network/Non-network combined) 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (Network/Non-network combined) \$4.000 Benefit maximum Physical Medicine Therapy Day Rehabilitation programs       0%       0%         • Hospice Care       0%       0%       0%		00/	09/
(copayment waived if admitted)     0%     0%       Inpatient and Outpatient Professional Services     0%     0%       Include but are not limited to:     0%     30%       • 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     0%     30%       Unlimited days except for:     0%     30%       • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)     0%     30%       • 90 days Network/Non-Network combined for skilled nursing facility     0%     30%       Outpatient Surgery Hospital/Alternative Care Facility     0%     30%       Other Outpatient Services (including but not limited to):     0%     30%       • Non Surgical Outpatient Services.     0%     30%       For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.     0%     30%       • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) 90 visits (excludes IV Therapy)     0%     30%       • Physical Medicine Therapy Day Rehabilitation programs     0%     0%     0%		0%	0%
• Urgent Care Center Services     0%     0%       Inpatient and Outpatient Professional Services     0%     30%       Include but are not limited to:     0%     30%       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     0%     30%       Unlimited days except for:     0%     30%       • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)     0%     30%       • 90 days Network/Non-Network combined for skilled nursing facility     0%     30%       Outpatient Surgery Hospital/Alternative Care Facility     0%     30%       • Surgery and administration of general anesthesia     0%     30%       Other Outpatient Services (including but not limited to):     0%     30%       • Non Surgical Outpatient Services.     0%     30%       • Home Care Services (Network/Non-network combined)     90 visits (cucludes IV Therapy)     30%       • Durable Medical Equipment and Orthotics (Network/Non-network combined)     0%     40%       • Home Care Services (Metwork/Non-network combined)     9%     0%       • Home Care Services (Mathing Prosthetic Devices and Medical Supplies)     9%     0%       • Physical Medicine Therapy Day Rehabilitation pr			
Inpatient and Outpatient Professional Services       0%       30%         Include but are not limited to:       0%       30%         • 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       0%       30%         Unlimited days except for:       0%       30%         • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%       30%         • 90 days Network/Non-Network combined for skilled nursing facility Outpatient Surgery Hospital/Atternative Care Facility       0%       30%         • Surgery and administration of general anesthesia       0%       30%         Other Outpatient Services (including but not limited to):       0%       30%         • Non Surgical Outpatient Services.       0%       30%         • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)       0%       30%         • Durable Medical Equipment and Othotics (Network/Non-network combined)       0%       0%         • Modical Supplies)       0%       0%       0%         • Hospice Care       0%       0%       0%		0%	0%
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%         Impatient Facility Services       0%       30%         Unlimited days except for:       0%       30%         • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%       30%         • 90 days Network/Non-Network combined for skilled nursing facility       0%       30%         Outpatient Surgery Hospital/Alternative Care Facility       0%       30%         • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.       0%       30%         • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)       0%       30%         • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)       0%       0%         • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)       0%       0%         • Physical Medicine Therapy Day Rehabilitation programs       0%       0%			
<ul> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> <li>Inpatient Facility Services</li> <li>Unlimited days except for:</li> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days Network/Non-Network combined for skilled nursing facility</li> <li>Outpatient Surgery Hospital/Alternative Care Facility</li> <li>Surgery and administration of general anesthesia</li> <li>Other Outpatient Services (including but not limited to):</li> <li>Non Surgical Outpatient services.</li> <li>Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)</li> <li>Durable Medical Equipment and Orthotics (Network/Non-network combined)</li> <li>S4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)</li> <li>Prosthetic Devices \$4,000 benefit maximum</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> </ul>			
Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams       0%         Inpatient Facility Services       0%         Unlimited days except for:       0%         60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%         90 days Network/Non-Network combined for skilled nursing facility       0%         Outpatient Surgery Hospital/Alternative Care Facility       0%         Surgery and administration of general anesthesia       0%         Other Outpatient Services (including but not limited to):       0%         Non Surgical Outpatient Services.       0%         Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)       0%         Durable Medical Equipment and Othotics (Network/Non-network combined) 94.000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) Prosthetic Devices \$4,000 benefit maximum       0%         Physical Medicine Therapy Day Rehabilitation programs       0%       0%			
of general anesthesia and Newborn exams       0%         Inpatient Facility Services       0%         Unlimited days except for:       0%         60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%         90 days Network/Non-Network combined for skilled nursing facility       0%         Outpatient Surgery Hospital/Alternative Care Facility       0%         Surgery and administration of general anesthesia       0%         Other Outpatient Services (including but not limited to):       0%         Non Surgical Outpatient Services, Chemotherapy, Ultrasounds and other diagnostic outpatient services.       0%         Home Care Services (Network/Non-network combined)       0%         90 visits (excludes IV Therapy)       0%         Durable Medical Equipment and Orthotics       0%         (Network/Non-network combined)       0%         90 visits (excludes IV Therapy)       0%         90 rosthetic Devices \$4,000 benefit maximum       0%         Physical Medicine Therapy Day Rehabilitation programs       0%			
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         Outpatient Surgery Hospital/Alternative Care Facility       0%       30%         Surgery and administration of general anesthesia       0%       30%         Other Outpatient Services (including but not limited to):       0%       30%         Non Surgical Outpatient Services       0%       30%         For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.       0%       30%         Home Care Services (Network/Non-network combined)       90 visits (excludes IV Therapy)       0%       30%         Durable Medical Equipment and Orthotics (Network/Non-network combined)       90 visits (cucluding Prosthetic Devices and Medical Supplies)       0%       0%         Prosthetic Devices \$4,000 benefit maximum       0%       0%       0%       0%			
<ul> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days Network/Non-Network combined for skilled nursing facility</li> <li>Outpatient Surgery Hospital/Alternative Care Facility</li> <li>Surgery and administration of general anesthesia</li> <li>Other Outpatient Services (including but not limited to):</li> <li>Non Surgical Outpatient Services, Chemotherapy, Ultrasounds and other diagnostic outpatient services.</li> <li>Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)</li> <li>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</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> </ul>	Inpatient Facility Services	0%	30%
medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       90 days Network/Non-Network combined for skilled nursing facility         Outpatient Surgery Hospital/Alternative Care Facility       0%         Surgery and administration of general anesthesia       0%         Other Outpatient Services (including but not limited to):       0%         Non Surgical Outpatient Services       0%         For example: NRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.       0%         Home Care Services (Network/Non-network combined)       90 visits (excludes IV Therapy)         Durable Medical Equipment and Orthotics (Network/Non-network combined)       94,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)         Prosthetic Devices \$4,000 benefit maximum       0%       0%         Physical Medicine Therapy Day Rehabilitation programs       0%	Unlimited days except for:		
<ul> <li>90 days Network/Non-Network combined for skilled nursing facility</li> <li>Outpatient Surgery Hospital/Alternative Care Facility</li> <li>Surgery and administration of general anesthesia</li> <li>Other Outpatient Services (including but not limited to):</li> <li>Non Surgical Outpatient Services</li> <li>For example: MRIs, CScans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.</li> <li>Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)</li> <li>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</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> </ul>	medicine/rehab (limit includes Day Rehabilitation Therapy		
Outpatient Surgery Hospital/Alternative Care Facility       0%       30%         • Surgery and administration of general anesthesia       0%       30%         Other Outpatient Services (including but not limited to):       0%       30%         • Non Surgical Outpatient Services       0%       30%         For example: MRIs, CScans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.       0%       30%         • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)       0       30%         • 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       0%       0%         • Physical Medicine Therapy Day Rehabilitation programs       0%       0%       0%	, ,		
Surgery and administration of general anesthesia       0%         Other Outpatient Services (including but not limited to):       0%         Non Surgical Outpatient Services       0%         For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.       0%         Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)       0         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       0%         Physical Medicine Therapy Day Rehabilitation programs       0%       0%			
Other Outpatient Services (including but not limited to):       0%       30%         • Non Surgical Outpatient Services       0%       30%         For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.       0%       30%         • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)       0       90         • 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       0%       0%         • Physical Medicine Therapy Day Rehabilitation programs       0%       0%       0%		0%	30%
<ul> <li>Non Surgical Outpatient Services</li> <li>For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.</li> <li>Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)</li> <li>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</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> </ul>	Surgery and administration of general anesthesia		
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 0%	Other Outpatient Services (including but not limited to):	0%	30%
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 0%	Non Surgical Outpatient Services		
<ul> <li>Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)</li> <li>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</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> </ul>			
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 0%	\$ I		
<ul> <li>Durable Medical Equipment and Orthotics         <ul> <li>(Network/Non-network combined)</li> <li>\$4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)</li> <li>Prosthetic Devices \$4,000 benefit maximum</li> </ul> </li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>0%</li> </ul>			
(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       0%			
Medical Supplies)       Prosthetic Devices \$4,000 benefit maximum         Physical Medicine Therapy Day Rehabilitation programs       0%         Hospice Care       0%			
Prosthetic Devices \$4,000 benefit maximum Physical Medicine Therapy Day Rehabilitation programs Hospice Care 0% 0%			
Physical Medicine Therapy Day Rehabilitation programs     Hospice Care     0%     0%     0%			
Hospice Care     0%     0%			
		0%	0%
	Ambulance Services	0%	

Anthem Blue Cross and Blue Sheld is the trade name of Anthers Insurance Companies, Inc. An independent licensee of the Stue Cross and Blue Shield Association. ®Registered marks Blue Cross and Blue Shield Association

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	0% 0%	30% 30%
Manipulation therapy: 12 visits     Speech therapy: 20 visits		
Behavioral Health Services: Mental Health and Substance Abuse <sup>1</sup> Inpatient Facility Services		
<ul> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	0% 0% 0%	30% 30% 30%
Human Organ and Tissue Transplants	0%	30%
Acquisition and transplant procedures, harvest and storage.     Prescription Drugs		
Network Tier structure equals 1/2/3 (and 4, if applicable) Network Retail Pharmacies: (30-day supply) Includes diabelic test strip	0%	30%7
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) <sup>3</sup>		
Medical	\$5 million	\$5 million
Surgical Treatment of Morbid Obesity (contributes toward the medical lifetime maximum)	Not covered	Not covered

All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).

٠

Deductible(s) apply to covered services listed with a percentage (2%) 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 calcudar year which the child ottains age 24.

No comment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. (9% 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/genecology, 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 vear

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. <sup>2</sup>Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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 curviliment 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 entive 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.

## Anthem. 🗣 🕅

## Your Summary of Benefits

### MSD of Wayne Township Blue Preferred<sup>®</sup> (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)	\$35/\$35
Primary Care Physician (PCP)/	
Specialty Care Physician (SCP)	
Including Office Surgeries and allergy serum:	
<ul> <li>allergy injections (PCP and SCP)</li> </ul>	No copayment/coinsurance (if billed with OV copay, then copay applies.)
• allergy testing	No copayment/coinsurance (if billed with OV copay, then copay applies.)
<ul> <li>routine and non-routine mammograms (regardless of outpatient setting)</li> </ul>	\$35
<ul> <li>diabetic education (regardless of outpatient setting)</li> </ul>	\$35
<ul> <li>certain medical nutritional therapy (regardless of outpatient setting)</li> </ul>	\$35
Preventive Care Services	
Services include but are not limited to:	
Routine Exams, Pelvic Exams, Pap testing, PSA tests,	
Immunizations <sup>1</sup> , Annual diabetic eye exam, Vision and	
Hearing screenings	
<ul> <li>Physician Home and Office Visits (PCP/SCP)</li> </ul>	\$35
Other Outpatient Services @ Hospital/Alternative     Care Facility	\$150
Emergency and Urgent Care	
Emergency Room Services	\$100
<ul> <li>facility/other covered services</li> </ul>	
(copayment waived if admitted)	
Urgent Care Center Services	\$50
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology	
Imaging Studies,	
• Allergy injections	
Allergy testing	
Inpatient and Outpatient Professional Services	No copayment/coinsurance
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	
Blue 3.0	

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, fric. Independent licensee of the Blue Cross and Blue Shield Association. ID ANTHEM is a registered trademak of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

## Your Summary of Benefits

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

### Your Summary of Benefits

Covered Benefits	Network
Prescription Drugs Network <sup>4</sup>	
Tier structure equals 1/2/3 (and 4, if applicable)	
Network Retail Pharmacies:	\$20/\$40/\$80/\$80
(30-day supply)	
Includes diabetic test strip	No copayment/coinsurance
<ul> <li>Anthem Rx Direct Mail Service: (90-day supply)</li> </ul>	\$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 <sup>5</sup>	
Medical	Unlimited
Surgical Treatment of Morbid Obesity	Unlimited

Notes:

- Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits. ٥
- ٥ 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. o
- Dependent age: to end of the month which the child attains age 26
- o 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. 0
- Ô. No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount.
- 0 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.
- 0 SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. o
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Ó Benefit period = calendar year
- Prosthetic limbs are unlimited and do not apply to the Plan Lifetime Maximum. Ö
- Ö 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.
- ٥ 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. Ö
- Preventive Prescription Drugs that meet the requirements of federal and state law. 0

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 Comea 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);

### 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 <u>www.dol.gov/ebsa/healthreform</u>. 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 <u>www.healthreform.gov</u>.

## Anthem 🚭 🕅

# MSD of Wayne Township Blue Access<sup>SM</sup> (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 RESPONSI	BILITY)
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 <ul> <li>Including Allergy – testing and treatment</li> <li>serum and injections<sup>1</sup></li> </ul>	\$35 Network/40% Non-network Per Visit	
Preventive Care	\$35 Network/40% Non-network Per Visit. Included with apply. Preventive care includes: medical history, mamm immunizations <sup>1</sup> , routine and annual diabetic eye exams	ograms <sup>1</sup> pelvic exams and Pap tests.
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 cop	
Spinal Manipulation	12 Network and Non-network combined visits; same cop	
Speech	20 Network and Non-network combined visits; same con	bay as office services
Mental Health and Substance Abuse <sup>2</sup>	Covered as any other illness. Subject to same copays, o	deductibles and maximums.
Lifetime Maximum	UNLIMITED	
Human Organ and Tissue Transplants <sup>3</sup>	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

- 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.
- <sup>1</sup> These covered services are covered in full if you have a flat dollar copayment and if rendered without an office services.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- <sup>4</sup> 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 <u>www.dol.gov/ebsa/healthreform</u>. 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 <u>www.healthreform.gov</u>.

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

## Anthem.

## Your Summary of Benefits

### 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	Single: \$2,000	Single: \$4,000
Family coverage requires the family deductible to be met	Family: \$4,000	Family: \$8,000
before coinsurance applies. The single deductible		
does not apply to family coverage.		
Out-of-Pocket Limit	Single: \$2,000	Single: \$4,000
	Family: \$4,000	Family: \$8,000
Physician Home and Office Services	0%	30%
<ul> <li>Including Office Surgeries, allergy serum, allergy injections and allergy testing</li> </ul>		
Preventive Care Services	No copayment/coinsurance	30%
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		
Emergency and Urgent Care		
<ul> <li>Emergency Room Services</li> </ul>	0%	0%
(facility/other covered services)		
(copayment waived if admitted)		
o Urgent Care Center Services	0%	0%
Inpatient and Outpatient Professional Services	0%	30%
Include but are not limited to:		
<ul> <li>Medical Care visits (1 per day), Intensive</li> </ul>		
Medical Care, Concurrent Care, Consultations.		
Surgery and administration of general		
anesthesia and Newborn exams		2001
Inpatient Facility Services (Network/Non-Network	0%	30%
combined) Unlimited days except for:		<b>W</b>
<ul> <li>60 days for physical medicine/rehab</li> </ul>		
(limit includes Day Rehabilitation Therapy		
Services on an outpatient basis)		
<ul> <li>90 days for skilled nursing facility</li> </ul>		
Outpatient Surgery Hospital/Alternative Care Facility	0%	30%
<ul> <li>Surgery and administration of</li> </ul>		
general anesthesia		

MSD of Wayne Township 3.0 PPO HSA SOB #H6 HCR

Anithem Blue Cross and Blue Shield is the trade name of Anithem Incurance Comparies, Inc. Independent foonsee of the Blue Cross and Blue Shield Association. IS ANTHEM it a registered (rademark of Anithem Insurance Companies, Inc. The Blue Cross and Blue Shield nemes and symbols are registered marks of the Blue Cross and Blue Shield Association.

Covere	d Benefits	Network	Non-Network
	Outpatient Services (Network/Non-network	0%	30%
	ed) including but not limited to:		
0			
	For example: MRIs, C-Scans,		
	Chemotherapy, Ultrasounds and		
	other diagnostic outpatient services.		
0	Home Care Services 90 visits (excludes IV		
	Therapy)		
0	Durable Medical Equipment and Orthotics		
	(excluding Prosthetic Devices, Limbs		
	and Medical Supplies)		
o	Prosthetic Devices		
0	Prosthetic Limbs		
0	Physical Medicine Therapy Day		
	Rehabilitation programs		
0	Hospice Care	0%	0%
٥	Ambulance Services	0%	0%
Accide	ntal Dental Services Unlimited	0%	30%
(Combin o Limits a o o o	Physical therapy: 20 visits Occupational therapy: 20 visits Manipulation therapy: 12 visits Speech therapy: 20 visits	0% 0%	30% 30%
	oral Health Service	0%	30%
	Illness and Substance Abuse1:		
0	Inpatient Facility Services		life
•	Inpatient Professional Services		
0	Physician Home and Office Visits (PCP/SCP)		
0	Other Outpatient Services, Outpatient Facility		
	@ Hospital/Alternative Care Facility,		
	Outpatient Professional.		
	Organ and Tissue Transplants	0%	30%
0	Acquisition and transplant procedures,		
	harvest and storage.		

Covered Benefits	Network	Non-Network
Prescription Drugs		
<ul> <li>Network Retail Pharmacies:</li> </ul>	0%	30%2
(30-day supply)		
Includes diabetic test strip		
<ul> <li>Anthem Rx Direct Mail Service:</li> </ul>	0%	Not covered
(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></select>		
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.

#### Grandiathered 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 <u>www.dol.gov/ebsa/healthreform</u>. 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 <u>www.healthreform.gov</u>.

## **Your Anthem Benefits**

# Anthem 🕾 🕅

### MSD of Wayne Township Blue Access<sup>SM</sup> (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 RESPONSI	BILITY)	
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 <ul> <li>Including Allergy – testing and treatment</li> <li>serum and injections<sup>1</sup></li> </ul>	\$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 benefit: apply. Preventive care includes: medical history, mammograms <sup>1</sup> , pelvic exams and Pap tests, immunizations <sup>1</sup> , 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 <sup>2</sup> Inpatient Facility Services Inpatient Professional Services	20% Network/40% Non-network 20% Network/40% Non-network		
Physician Home and Office Visits (PCP/SCP)	\$35 Network/40% Non-network		
<ul> <li>Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional     </li> </ul>			
Lifetime Maximum	UNLIMITED		
Human Organ and Tissue Transplants <sup>3</sup>	Covered in full Network/50% Non-network (Does not coun	t 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	

### 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

DeductibleSingle: \$2,000Single: \$4,000Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.Single: \$2,000Family: \$4,000Out-of-Pocket LimitSingle: \$2,000Single: \$2,000Family: \$4,000Physician Home and Office Services • Including Office Surgeries, altergy testing0%30%Preventive Care ServicesNo copayment/coinsurance30%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 (facility/other covered services) (copayment waived if admitted)0%30%• Emergency Room Services (facility/other covered services) (copayment waived if admitted)0%30%• Medical Care visits (1 per day), Intensive Medical Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%• 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient Association for general anesthesia and Newborn exams0%30%• 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient handicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basic0%30%• 90 days for skilled nursing facility0%30%	Covered Benefits	Network	Non-Network
Family coverage requires the family deductible to be met before coinsurance apply to family coverage.Family: \$4,000Family: \$8,000Out-of-Pocket LimitSingle: \$2,000 Family: \$4,000Single: \$8,000Physician Home and Office Services • Including Office Surgeries, altergy serum, allergy injections and altergy testing0%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 Usion and Hearing exams • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility0%30%Emergency and Urgent Care • Emergency and Urgent Care Services (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services • Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%• Madieal Care, Concurrent Care, Consultations, Surgery and Administration of general anesthesia and Newborn exams0%30%• Sold ays for skilled nursing facility0%30%• Surgery and administration of general anesthesia0%30%			· · · · · · · · · · · · · · · · · · ·
before coinsurance applies. The single deductible       Image: Standing of the single deductible         does not apply to family coverage.       Single: \$2,000       Single: \$8,000         Physician Home and Office Services       0%       30%         Including Office Surgeries, allergy serum, allergy injections and allergy testing       No copayment/coinsurance       30%         Preventive Care Services       No copayment/coinsurance       30%         Services include but are not limited to:       No copayment/coinsurance       30%         Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams       No copayment/coinsurance       30%         Other Outpatient Services @       No       0%       0%       0%         Emergency and Urgent Care       0%       0%       0%       0%         Include but are not limited to:       0%			
does not apply to family coverage.     Single: \$2,000     Single: \$8,000       Dut-of-Pocket Limit     Single: \$2,000     Family: \$16,000       Physician Home and Office Services     0%     30%       • Including Office Surgeries, allergy serum, allergy injections and allergy testing     0%     30%       Preventive Care Services     No copayment/coinsurance     30%       Services include but are not limited to:     No copayment/coinsurance     30%       Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams     0%     0%       • Dhysician Home and Office Visits     0%     0%     0%       • Emergency Room Services     0%     0%     0%       (facility/other covered services)     0%     0%     0%       (copayment waived if admitted)     0%     30%       • Medical Care visits (1 per day), Intensive     0%     30%       • Medical Care visits (1 per day), Intensive     0%     30%       • Medical Care visits (1 per day), Intensive     0%     30%       • Medical Care visits (1 per day), Intensive     0%     30%       • Medical Care visits (1 per day), Intensive     0%     30%       • Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams     0%     30%       • 90 days fo		1 anny, \$4,000	1 anny: \$0,000
Out-of-Pocket LimitSingle: \$2,000 Family: \$4,000Single: \$8,000 Family: \$16,000Physician Home and Office Services oIncluding Office Surgeries, allergy serum, allergy injections and allergy testing0%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 oNo copayment/coinsurance30%Physician Home and Office Visits oOther Outpatient Services @ Hospital/Alternative Care Facility0%0%Emergency and Urgent Care (facility/other covered services) (copayment waived if admitted)0%0%• Emergency Room Services (facility/other covered services) (copayment waived if admitted)0%0%• Urgent Care Center Services (matical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%• patient Facility Services (Network/Non-Network ombined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient Therapy Services on an outpatient facility0%30%• Surgery and administration of general anesthesia0%30%	· · · · -		
Family: \$4,000Family: \$10,000Physician Home and Office Services 		Single: \$2,000	Single: \$2,000
Physician Home and Office Services       0%       30%         • Including Office Surgeries, allergy serum, allergy injections and allergy testing       0%       30%         Preventive Care Services       0%       30%         Services include but are not limited to:       0%       30%         Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams       No copayment/coinsurance       30%         • Physician Home and Office Visits       0       0%       0%         • Other Outpatient Services @ Hospital/Alternative Care Facility       0%       0%         Emergency and Urgent Care       0%       0%       0%         • Emergency Room Services (copayment waived if admitted)       0%       0%       0%         • Urgent Care Center Services npatient and Outpatient Professional Services nclude but are not limited to:       0%       30%         • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams       0%       30%         • Other outpatient Professional medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%       30%         • 90 days for shilled nursing facility       0%       30%       30%       30% <td></td> <td></td> <td></td>			
<ul> <li>Including Office Surgeries, allergy serum, allergy injections and allergy testing</li> <li>Preventive Care Services</li> <li>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</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> <li>Emergency and Urgent Care</li> <li>Emergency Room Services (facility/other covered services) (copayment waived if admitted)</li> <li>Urgent Care Center Services</li> <li>Medical Care visits (1 per day), Intensive Medical Care visits (1 per day), Intensive Medical Care concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> <li>Medical Say for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days for skilled nursing facility</li> <li>Surgery and administration of general anesthesia</li> </ul>			Failiny. \$10,000
allergy injections and allergy testingNo copayment/coinsurancePreventive Care ServicesNo copayment/coinsurance30%Services include but are not limited to:No copayment/coinsurance30%Routine Exams, Manmograms, Pelvic Exams, Pap lesting, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing examsNo copayment/coinsurance30%• Physician Home and Office Visits•Physician Home and Office Visits•• Other Outpatient Services @ Hospital/Alternative Care Facility0%0%Emergency and Urgent Care (copayment waived if admitted)0%0%• Urgent Care Center Services (copayment waived if admitted)0%30%• Urgent Care Center Services (copayment waived if admitted)0%30%• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%• 6 0d days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%30%• 90 days for skilled nursing facility0%30%		0%	30%
Preventive Care Services       No copayment/coinsurance       30%         Services include but are not limited to:       No copayment/coinsurance       30%         Routine Exams, Manmograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams       No copayment/coinsurance       30%         • Physician Home and Office Visits       Other Outpatient Services @       No copayment/coinsurance       30%         • Other Outpatient Services @       Hospital/Alternative Care Facility       0%       0%         Emergency and Urgent Care       0%       0%       0%         • Emergency Room Services (copayment waived if admitted)       0%       0%       0%         • Urgent Care Center Services       0%       0%       30%         • Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams       0%       30%         • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%       30%         • 90 days for skilled nursing facility       0%       30%			
Services include but are not limited to:       In the opplythere constants       In the opplythere constants         Routine Exams, Mammograms, Pelvic Exams, Pap lesting, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams       In the opplythere constants       In the opplythere constants         Image: Provide of the opplythere constants       Physician Home and Office Visits       Image: Provide of the opplythere constants       Image: Provide of the opplythere constants         Image: Provide of the opplythere constants       Image: Provide of the opplythere constants       Image: Provide of the opplythere constants       Image: Provide of the opplythere constants         Image: Provide of the opplythere constants       Image: Provide of the opplythere constants       Image: Provide of the opplythere constants       Image: Provide of the opplythere constants         Image: Provide of the opplythere constants       Image: Provide of the opplythere constants       Image: Provide of the opplythere constants       Image: Provide of the opplythere constants         Image: Provide of the opplythere constants       Image: Provide of the opplythere       Image: Provide of the opplythere       Image: Provide of the opplythere         Image: Provide of the opplythere constants       Image: Provide of the opplythere       Image: Provide of the opplythere       Image: Provide of the opplythere         Image: Provide of the opplythere       Image: Provide of the opplythere       Image: Provide of the opplythere       Image: Provide			
Routine Exams, Mammograms, Pelvic Exams, Pap       Pap         testing, PSA tests, Immunizations, Annual diabetic eye       Physician Home and Office Visits         • Physician Home and Office Visits       Physician Home and Office Visits         • Other Outpatient Services @       Phospital/Alternative Care Facility         Emergency and Urgent Care       0%         • Emergency Room Services       0%         (copayment waived if admitted)       0%         • Urgent Care Center Services       0%         noticed Care visits (1 per day), Intensive       0%         Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams       0%         anesthesia and Newborn exams       0%         • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%         • 90 days for skilled nursing facility       0%         • 90 days for skilled nursing facility       0%		No copayment/coinsurance	30%
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         Emergency and Urgent Care         • Emergency Room Services (facility/other covered services) (copayment waived if admitted)       0%         • Urgent Care Center Services (copayment waived if admitted)       0%         • Urgent Care Center Services (copayment waived if admitted)       0%         • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams       0%         anesthesia and Newborn exams       0%       30%         • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%       30%         • 90 days for skilled nursing facility       0%       30%			
exam, Routine Vision and Hearing exams <ul> <li>Physician Home and Office Visits</li> <li>Other Outpatient Services @ <ul> <li>Hospital/Alternative Care Facility</li> </ul> </li> <li>Emergency and Urgent Care <ul> <li>Emergency Room Services</li> <li>(facility/other covered services)</li> <li>(copayment waived if admitted)</li> <li>Urgent Care Center Services</li> <li>(copayment waived if admitted)</li> <li>Urgent Care Center Services</li> <li>0%</li> </ul> </li> <li>o Hedical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> <li>npatient Facility Services (Network/Non-Network combined) Unlimited days except for: <ul> <li>60 days for physical medicine/rehab</li> <li>(limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days for skilled nursing facility</li> </ul> </li> <li>Dutpatient Surgery Hospital/Alternative Care Facility</li> <li>Surgery and administration of general anesthesia</li> </ul>	Routine Exams, Mammograms, Pelvic Exams, Pap		
<ul> <li>Physician Home and Office Visits</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> <li>Emergency and Urgent Care</li> <li>Emergency Room Services (facility/other covered services) (copayment waived if admitted)</li> <li>Urgent Care Center Services</li> <li>O%</li> </ul>	testing, PSA tests, Immunizations, Annual diabetic eye		
• Other Outpatient Services @ Hospital/Alternative Care Facility       0         Emergency and Urgent Care       0%         • Emergency Room Services (facility/other covered services) (copayment waived if admitted)       0%       0%         • Urgent Care Center Services (copayment waived if admitted)       0%       0%         • Urgent Care Center Services (copayment waived if admitted)       0%       0%         • Urgent Care Center Services nclude but are not limited to:       0%       30%         • Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams       0%       30%         • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility       0%       30%         • Surgery and administration of general anesthesia       0%       30%	exam, Routine Vision and Hearing exams		
Hospital/Alternative Care FacilityEmergency and Urgent Care • Emergency Room Services (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services (copayment waived if admitted) • Urgent Care Center Services nolude 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%0%30%npatient Facility Services (Network/Non-Network (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility0%30%Outpatient Surgery and administration of general anesthesia0%30%Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia0%30%	<ul> <li>Physician Home and Office Visits</li> </ul>		
Emergency and Urgent Care0%0%• Emergency Room Services (facility/other covered services) (copayment waived if admitted)0%0%• Urgent Care Center Services0%0%• Urgent Care Center Services0%0%npatient and Outpatient Professional Services nclude but are not limited to:0%30%• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%• 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%30%• 90 days for skilled nursing facility0%30%	<ul> <li>Other Outpatient Services @</li> </ul>		
• Emergency Room Services (facility/other covered services) (copayment waived if admitted)0%0%• Urgent Care Center Services (copayment waived if admitted)0%0%• Urgent Care Center Services nolude 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 exams0%30%• 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 facility0%30%• Surgery and administration of general anesthesia0%30%	Hospital/Alternative Care Facility		
(facility/other covered services) (copayment waived if admitted)0%0%• Urgent Care Center Services0%0%npatient and Outpatient Professional Services0%30%nclude but are not limited to:0%30%• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%• facility Services (Network/Non-Network combined) Unlimited days except for:0%• 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%• 90 days for skilled nursing facility0%• Surgery and administration of general anesthesia30%	Emergency and Urgent Care		
(copayment waived if admitted)0%0%• Urgent Care Center Services0%0%npatient and Outpatient Professional Services0%30%nclude but are not limited to:0%30%• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%npatient Facility Services (Network/Non-Network tombined) Unlimited days except for:0%30%• 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%30%• 90 days for skilled nursing facility0%30%	• Emergency Room Services	0%	0%
•Urgent Care Center Services0%0%npatient and Outpatient Professional Services0%30%nclude but are not limited to:•%30%•Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%npatient Facility Services (Network/Non-Network combined) Unlimited days except for:0%30%•60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%30%•90 days for skilled nursing facility0%30%	(facility/other covered services)		
npatient and Outpatient Professional Services0%30%nclude but are not limited to:0%30%• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%• npatient Facility Services (Network/Non-Network combined) Unlimited days except for:0%30%• 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%30%• 90 days for skilled nursing facility0%30%• Surgery and administration of general anesthesia0%30%	(copayment waived if admitted)		
npatient and Outpatient Professional Services0%30%nclude but are not limited to:0%30%• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%30%• npatient Facility Services (Network/Non-Network combined) Unlimited days except for:0%30%• 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%30%• 90 days for skilled nursing facility0%30%• Surgery and administration of general anesthesia0%30%	• Urgent Care Center Services	0%	0%
<ul> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> <li>npatient Facility Services (Network/Non-Network combined) Unlimited days except for:</li> <li>60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days for skilled nursing facility</li> <li>Ottpatient Surgery Hospital/Alternative Care Facility Surgery and administration of general anesthesia</li> </ul>	Inpatient and Outpatient Professional Services	0%	
Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%anesthesia and Newborn exams0%anesthesia and Newborn exams0%anesthesia and Newborn exams0%anesthesia and Newborn exams0%sombined) Unlimited days except for: (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%90 days for skilled nursing facility0%Outpatient Surgery Hospital/Alternative Care Facility general anesthesia0%	Include but are not limited to:		
Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams0%anesthesia and Newborn exams0%anesthesia and Newborn exams0%anesthesia and Newborn exams0%anesthesia and Newborn exams0%sombined) Unlimited days except for: (limit includes Day Rehabilitation Therapy Services on an outpatient basis)0%90 days for skilled nursing facility0%Outpatient Surgery Hospital/Alternative Care Facility general anesthesia0%	• Medical Care visits (1 per day), Intensive		
anesthesia and Newborn exams       0%         npatient Facility Services (Network/Non-Network       0%         sombined) Unlimited days except for:       0%         • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%         • 90 days for skilled nursing facility       0%         Outpatient Surgery Hospital/Alternative Care Facility general anesthesia       0%			
anesthesia and Newborn exams       0%         npatient Facility Services (Network/Non-Network       0%         sombined) Unlimited days except for:       0%         • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)       0%         • 90 days for skilled nursing facility       0%         Outpatient Surgery Hospital/Alternative Care Facility general anesthesia       0%	Surgery and administration of general		
npatient Facility Services (Network/Non-Network       0%       30%         sombined) Unlimited days except for:       0%       30%         • 60 days for physical medicine/rehab       0%       30%         (limit includes Day Rehabilitation Therapy       Services on an outpatient basis)       90 days for skilled nursing facility         • 90 days for skilled nursing facility       0%       30%         • Surgery and administration of general anesthesia       0%       30%			
combined)       Unlimited days except for:       60 days for physical medicine/rehab         (limit includes Day Rehabilitation Therapy       Services on an outpatient basis)         o       90 days for skilled nursing facility         Outpatient Surgery Hospital/Alternative Care Facility       0%         Surgery and administration of general anesthesia       30%		0%	30%
<ul> <li>60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days for skilled nursing facility</li> <li>90 days for skilled nursing facility</li> <li>0%</li> <li>30%</li> <li>Surgery and administration of general anesthesia</li> </ul>			
(limit includes Day Rehabilitation Therapy Services on an outpatient basis)       90         • 90 days for skilled nursing facility       90         Outpatient Surgery Hospital/Alternative Care Facility       0%         • Surgery and administration of general anesthesia       30%			
Services on an outpatient basis)       90 days for skilled nursing facility         Outpatient Surgery Hospital/Alternative Care Facility       0%         Surgery and administration of general anesthesia       0%			
•       90 days for skilled nursing facility         Outpatient Surgery Hospital/Alternative Care Facility       0%         •       Surgery and administration of general anesthesia			
Outpatient Surgery Hospital/Alternative Care Facility       0%       30%         • Surgery and administration of general anesthesia       0%       30%	· ,		
<ul> <li>Surgery and administration of general anesthesia</li> </ul>		0%	30%
general anesthesia	· · · · · ·		
	• •		
	Blue 3.0	_1	1

Covered Benefits	Network in the second second second	Non-Network
Prescription Drugs		
• Network Retail Pharmacies: (30-day supply)	0%	30%2
<ul> <li>Includes diabetic test strip</li> <li>Anthem Rx Direct Mail Service: (90-day supply)</li> </ul>	0%	Not covered
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></select>		
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

### MSD of Wayne Township Blue Preferred<sup>®</sup> (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)	\$35/\$35
Primary Care Physician (PCP)/	
Specialty Care Physician (SCP)	
Including Office Surgeries and allergy serum:	
<ul> <li>allergy injections (PCP and SCP)</li> </ul>	No copayment/coinsurance (if billed with OV copay, then copay applies.)
• allergy testing	No copayment/coinsurance (if billed with OV copay, then copay applies.)
• routine and non-routine mammograms (regardless of	\$35
outpatient setting)	
• diabetic education (regardless of outpatient setting)	\$35
• certain medical nutritional therapy (regardless of	\$35
outpatient setting)	
Preventive Care Services	
Services include but are not limited to:	
Routine Exams, Pelvic Exams, Pap testing, PSA tests,	
Immunizations <sup>1</sup> , Annual diabetic eye exam, Vision and	
Hearing screenings	<b>1</b> 05
Physician Home and Office Visits (PCP/SCP)	\$35
Other Outpatient Services @ Hospital/Alternative     Care Facility	\$150
Care Facility Emergency and Urgent Care	
	C100
Emergency Room Services	\$100
• facility/other covered services	
(copayment waived if admitted)	¢50
Urgent Care Center Services	\$50
<ul> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies,</li> </ul>	
<ul> <li>Allergy injections</li> </ul>	
<ul> <li>Allergy testing</li> </ul>	
Inpatient and Outpatient Professional Services	No consument/asingurance
Include but are not limited to:	No copayment/coinsurance
• Medical Care visits (1 per day), Intensive Medical	
Care, Concurrent Care, Consultations, Surgery	
and administration of general anesthesia and	
Newborn exams	
Blue 3.0	

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

Covered Benefits	Network
Prescription Drugs Network <sup>4</sup>	
Tier structure equals 1/2/3 (and 4, if applicable)	
• Network Retail Pharmacies:	\$20/\$40/\$80/\$80
(30-day supply)	
Includes diabetic test strip	No copayment/coinsurance
• Anthem Rx Direct Mail Service:	\$40/\$80/\$160/\$160
(90-day supply)	
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 <sup>5</sup>	
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):

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 <u>www.dol.gov/ebsa/healthreform</u>. 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 <u>www.healthreform.gov</u>.

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

### 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	Single: \$2,000	Single: \$4,000
Family coverage requires the family deductible to be met	Family: \$4,000	Family: \$8,000
before coinsurance applies. The single deductible		1 unity: \$0,000
does not apply to family coverage.		
Out-of-Pocket Limit	Single: \$2,000	Single: \$8,000
	Family: \$4,000	Family: \$16,000
Physician Home and Office Services	0%	
• Including Office Surgeries, allergy serum,	0%	30%
allergy injections and allergy testing		
Preventive Care Services		
Services include but are not limited to:	No copayment/coinsurance	30%
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		
Emergency and Urgent Care		
• Emergency Room Services	0%	0%
(facility/other covered services)	0 78	0%
(copayment waived if admitted)		
• Urgent Care Center Services	0%	0%
Inpatient and Outpatient Professional Services	0%	
Include but are not limited to:	0 /8	30%
<ul> <li>Medical Care visits (1 per day), Intensive</li> </ul>		
Medical Care, Concurrent Care, Consultations,		
Surgery and administration of general		
anesthesia and Newborn exams		
Inpatient Facility Services (Network/Non-Network	0%	30%
combined) Unlimited days except for:		30%
• 60 days for physical medicine/rehab		
(limit includes Day Rehabilitation Therapy		
Services on an outpatient basis)		
• 90 days for skilled nursing facility		
Outpatient Surgery Hospital/Alternative Care Facility	0%	30%
• Surgery and administration of		50 %
general anesthesia		
Blue 3.0		

Covered Benefits	Network	Non-Network
Other Outpatient Services (Network/Non-network	0%	30%
combined) including but not limited to:		
Non Surgical Outpatient Services		
For example: MRIs, C-Scans,		
Chemotherapy, Ultrasounds and		
other diagnostic outpatient services.		
-		
Therapy)		
<ul> <li>Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, Limbs)</li> </ul>		
and Medical Supplies)		
Prosthetic Devices		
Prosthetic Limbs     Device Medicine Therepy Device		
Physical Medicine Therapy Day		
Rehabilitation programs	0%	0%
Hospice Care	0% 0%	0%
Ambulance Services		
Accidental Dental Services Unlimited	0%	30%
Outpatient Therapy Services		
(Combined Network & Non-Network limits apply)		
<ul> <li>Physician Home and Office Visits</li> </ul>	0%	30%
<ul> <li>Other Outpatient Services @</li> </ul>	0%	30%
Hospital/Alternative Care Facility		
Limits apply to:		
<ul> <li>Physical therapy: 20 visits</li> </ul>		
<ul> <li>Occupational therapy: 20 visits</li> </ul>		
<ul> <li>Manipulation therapy: 12 visits</li> </ul>		
• Speech therapy: 20 visits		
Behavioral Health Service	0%	30%
Mental Illness and Substance Abuse1:		
Inpatient Facility Services		
<ul> <li>Inpatient Professional Services</li> </ul>		
• Physician Home and Office Visits (PCP/SCP)		
• Other Outpatient Services, Outpatient Facility		
@ Hospital/Alternative Care Facility,		
Outpatient Professional.		
Human Organ and Tissue Transplants	0%	30%
• Acquisition and transplant procedures,		
harvest and storage.		

Covered Benefits	Network	Non-Network
<ul> <li>Prescription Drugs         <ul> <li>Network Retail Pharmacies: (30-day supply) Includes diabetic test strip</li> <li>Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip</li> </ul> </li> <li>Specialty medications are limited up to a 30 day supply</li> </ul>	0% 0%	30%² Not covered
regardless of whether they are retail or mail service. Medicare Rx <select> Lifetime Maximum</select>	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 <u>www.dol.gov/ebsa/healthreform</u>. 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 <u>www.healthreform.gov</u>.

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
	<u>HMO</u>	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
	<u>HSA</u>	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
	<u>HSA</u>	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
	<u>HMO</u>	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
	<u>PPO</u>	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

Anthem Rates by Position 01-01-07 7/16/2012

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
	<u>HMO</u>	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
	<u>HMO</u>	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
****	<u>HMO</u>	Single	385.32	306.00	153.00	39.66
*Technology Application		Empl + Child	1,001.87	495.00	247.50	253.44
Specialist *Production Printer *College Admissions		Empl + Spouse	1,051.93	495.00	247.50	278.47
		Family	1,413.98	542.00	271.00	435.99
Coordinator	PPO	Single	438.64	306.00	153.00	66.32
*Security Officer		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
i		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
	<u>HMO</u>	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
	<u>L</u>	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
	<u>HMO</u>	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
	<u>PPO</u>	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
	<u>HSA</u>	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/			Total	Monthly	Board	Employee
Special Ed			Monthly	Board	Contribution	Premium
Transportation Mgr	Plan	Coverage	Premium	Contribution	Per Pay	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

4

,

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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
	<u>PPO</u>	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
	<u>HSA</u>	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
	<u>HMO</u>	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

Anthem Rates by Position 01-01-07 6/20/2007

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
	<u>HMO</u>	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

٠

Custodian/Maintenance	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	нмо	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
	<u>HSA</u>	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
	<u>HMO</u>	Single	385.32	327.00	163.50	29.16
*Technology Application Specialist *Production Printer		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
*College Admissions						
Coordinator	<u>PPO</u>	Single	438.64	327.00	163.50	55.82
*Security Officer		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
	<u>HSA</u>	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
	<u>HMO</u>	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

4

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employ <del>ee</del> 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
	<u>HSA</u>	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
	<u>HMO</u>	Single	385.32	268.00	134.00	58.66
		Empl + Child	1,001.87	336.00	168.00	332.94
1		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			Total Monthly	Monthly Board	Board Contribution	Employee Premium
Transportation Mgr	Plan	Coverage	Premium	Contribution	Per Pay	Per Pay
	<u>HMO</u>	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

<u>ه</u> د د

·

. .

.

# 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
	<u>HMO</u>	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
	<u>HMO</u>	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

Anthem Rates 9-1-07 7/16/2012

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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
	<u>HSA</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	Single	385.32	327.00	163.50	29.16
*Technology Application		Empl + Child	1,001.87	530.00 <sup>°</sup>	265.00	235.94
Specialist		Empl + Spouse	1,051.93	530.00	265.00	260.97
*Production Printer		Family	1,413.98	580.00	290.00	416.99
*College Admissions						
Coordinator	PPO	Single	438.64	327.00	163.50	55.82
*Security Officer		Empl + Child	1,140.40	530.00	265.00	305.20
		Empl + Spouse	1,196.99	530.00	265.00	333.50
	ļ	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
L		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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HSA</u>	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/			Total	Monthly	Board	Employee
Special Ed			Monthly	Board	Contribution	Premium
Transportation Mgr	Plan	Coverage	Premium	Contribution	Per Pay	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
	<u>HMO</u>	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
	<u>HSA</u>	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

Anthem Rates 12-15-07 7/16/2012

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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	Emplo <del>yee</del> Premium Per Pay
	<u>HMO</u>	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
	<u>HMO</u>	Single	385.32	321.00	160.50	32.16
*Technology Application		Empl + Child	1,001.87	520.00	260.00	240.94
Specialist		Empl + Spouse	1,051.93	520.00	260.00	265.97
*Production Printer		Family	1,413.98	569.00	284.50	422.49
*College Admissions						
Coordinator	<u>PPO</u>	Single	438.64	321.00	160.50	58.82
*Security Officer		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
	<u>HMO</u>	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
	<u>HMO</u>	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/			Total	Monthly	Board	Employee
Special Ed			Monthly	Board	Contribution	Premium
Transportation Mgr	Plan	Coverage	Premium	Contribution	Per Pay	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
	РРО	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

4

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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
	<u>PPO</u>	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
	<u>HMO</u>	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
	<u>PPO</u>	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
	ļ					
	<u>HSA</u>	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
	<u>HMO</u>	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

Anthem Rates by Position.xls 7/15/2008

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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>PPO</u>	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
	<u>HSA</u>	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
	<u>HMO</u>	Single	433.27	350.00	175.00	41.64
*Technology Application Specialist *Production Printer		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
*College Admissions						
Coordinator	<u>PPO</u>	Single	475.30	350.00	175.00	62.65
*Security Officer		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
	<u>HSA</u>	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
	<u>PPO</u>	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
	<u>HMO</u>	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			Total	Monthly	Board	Employee
Manager			Monthly	Board	Contribution	Premium
	Plan	Coverage	Premium	Contribution	Per Pay	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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HSA</u>	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

Anthem Rates 9-1-08 7/16/2012

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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
I		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
	<u>HMO</u>	Single	519.92	420.00	210.00	49.96
	1	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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	Single	433.27	350.00	175.00	41.64
*Technology Application Specialist *Production Printer		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
*College Admissions						
Coordinator	<u>PPO</u>	Single	475.30	350.00	175.00	62.65
*Security Officer		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
	<u>HSA</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HSA</u>	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			Total	Monthly	Board	Employee
Manager			Monthly	Board	Contribution	Premium
	Plan	Coverage	Premium	Contribution	Per Pay	Per Pay
	<u>HMO</u>	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

٠

٠

Administrator	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	НМО	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
	<u>PPO</u>	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
	<u>HMO</u>	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

Anthem Rates By Position 2009.xls 11/14/2008

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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
	НМО	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	Emplo <del>yee</del> Premium Per Pay
	нмо	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
	<u>PPO</u>	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
	L	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
*Toobpology Appliestics	нмо	Single	472.26	350.00	175.00	61.13
*Technology Application Specialist *Production Printer *College Admissions Coordinator		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
	<u>PPO</u>	Single	522.83	350.00	175.00	86.42
*Security Officer		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
	1	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

1

.

-

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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
	1	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
	нмо	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
	нмо	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
	<u>PPO</u>	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
	<u>HSA</u>	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

Anthem Rates 9-1-09.xls 9/2/2009

2 Teacher	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	НМО	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
	НМО	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
	<u>PPO</u>	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
	L	Empl + Child	1,306.43	597.60	298.80	354.41
		Empl + Spouse	1,371.75	597.60	298.80	387.08
	1	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
	НМО	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
	нмо	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
	<u>PPO</u>	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
*Teshaslas A. K. K.	<u>HMO</u>	Single	472.26	375.00	187.50	48.63
*Technology Application Specialist *Production Printer *College Admissions Coordinator		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
*Security Officer		Empl + Child	1,359.38	607.00	303.50	376.19
*Grade Reporting		Empl + Spouse	1,426.88	607.00	303.50	409.94
Specialist		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

Anthem Rates 9-1-09.xls 9/2/2009

٠

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	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 9-1-09.xls 9/2/2009

#### 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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HSA</u>	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
	<u>HMO</u>	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
	<u> </u>	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
	<u>HMO</u>	Single	519.49	375.00	187.50	72.25
*Technology Application Specialist *Production Printer		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
*College Admissions						
Coordinator	PPO	Single	575.11	375.00	187.50	100.06
*Security Officer		Empl + Child	1,495.32	607.00	303.50	444.16
*Grade Reporting		Empl + Spouse	1,569.57	607.00	303.50	481.29
Specialist		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
	<u>HMO</u>	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

Anthem Rates 12-15-09 7/16/2012

Cafeteria Manager	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	<u>HMO</u>	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
	<u>HMO</u>	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			Total	Monthly	Board	Employee
Manager			Monthly	Board	Contribution	Premium
	Plan	Coverage	Premium	Contribution	Per Pay	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
	нмо	Empl + Spouse	1,546.08	1,530.62	765.31	7.73
		Family	2,078.23	2,057.45	1,028.72	10.39
	<u>PPO</u>	Empl + Spouse	1,726.53	1,709.26	854.63	8.63
		Family	2,321.72	2,298.50	1,149.25	11.61
	<u>HSA</u>	Empl + Spouse	1,307.74	1,294.66	647.33	6.54
L		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
	<u>HMO</u>	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
	<u>PPO</u>	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
	<u>HSA</u>	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
	<u>HMO</u>	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
	<u>HSA</u>	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
i .		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
	<u>HMO</u>	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	Employ <del>ee</del> Premium Per Pay
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	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
	HMO	Single	566.24	375.00	187.50	95.62
*Technology Application		Empl + Child	1,472.48	607.00	303.50	432.74
Specialist *Production Printer *College Admissions		Empl + Spouse	1,546.08	607.00	303.50	469.54
		Family	2,078.23	664.00	332.00	707.12
	L					
Coordinator	<u>PPO</u>	Single	632.62	375.00	187.50	128.81
*Security Officer		Empl + Child	1,644.85	607.00	303.50	518.93
*Grade Reporting		Empl + Spouse	1,726.53	607.00	303.50	559.77
Specialist		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
	<u>HMO</u>	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			Total Monthly	Monthly Board	Board Contribution	Employee Premium
	Plan	Coverage	Premium	Contribution	Per Pay	Per Pay
	<u>HMO</u>	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
	<u>PPO</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>PPO</u>	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
	<u>HSA</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	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
	<u>HMO</u>	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
***	<u>HMO</u>	Single	513.59	354.00	177.00	79.80
*Technology Application		Empl + Child	1,335.55	573.01	286.51	381.27
Specialist		Empl + Spouse	1,402.31	573.01	286.51	414.65
*Security Officer *Grade Reporting Specialist		Family	1,884.98	626.82	313.41	629.08
	<u>PPO</u>	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

-----

٢

Support Staff	Plan	Coverage	Total Monthly Premium	Monthly Board Contribution	Board Contribution Per Pay	Employee Premium Per Pay
	НМО	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
	<u>HMO</u>	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
	<u> </u>	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	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			Total	Monthly	Board	Employee
manayer	Plan	Coverage	Monthly Premium	Board Contribution	Contribution	Premium
					Per Pay	Per Pay
	<u>HMO</u>	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
	РРО	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