

**October 2008
Certificated**

PLANS	40607A PBC 100%-A		40607C PBC 100%-C \$10		40607D PBC 90%-C \$30	
	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Services						
Provider Network(s):	Prudent Buyer Prudent Buyer		Prudent Buyer Prudent Buyer		Prudent Buyer Prudent Buyer	
Hospital						
Professional						
Calendar Year Deductible(s)	\$0		\$200 per individual/\$400 per family		\$200 per individual/\$500 per family	
Maximum *Co-Insurance	Not applicable		Not applicable		\$300/individual	
<i>Co-insurance is the member's responsibility to pay when the plan is paying less than 100% (i.e. plan pays 80%, member pays the other 20%)</i>	Not applicable		Not applicable		Once the member's 10% co-insurance totals \$300, the plan will pay 100% of the allowable amount for the remainder of the calendar year.	
Inpatient Hospital Room, Board & Support Services (prior authorization required)	100%	\$540 - \$580 per day	100%	\$540 - \$580 per day	90%	\$540 - \$580 per day
Ambulatory Surgery Center	100%	\$540 - \$580 per day	100%	\$540 - \$580 per day	90%	\$540 - \$580 per day
Emergency Room (non-emergency) Facility Expenses:	100%	100% eligible expenses less 25%	100%	100% eligible expenses less 25%	100%	100% eligible expenses less 25%
Professional Expenses:		100% C&R		100% C&R		100% eligible expenses less 25% Non-Par Fee Life Threatening 100%
Skilled Nursing Facility (medically necessary)	100% up to 100 days per confinement	100% up to 100 days per confinement	100% up to 100 days per confinement	100% up to 100 days per confinement	90% up to 100 days per confinement	90% up to 100 days per confinement
Surgeon & Anesthetist	100%	Non-Par Fee	100%	Non-Par Fee	90%	Non-Par Fee
Accident Care (Professional) (initial care)	100%	100% C&R	100%	100% C&R	90%	90% C&R
Preventative Care (age 0 - 25)	100%	Non-Par Fee	100%	Non-Par Fee	90%	Non-Par Fee
Routine Exam Employee & Spouse (Deductible Waived)	100%	Non-Par Fee	100%	Non-Par Fee	90%	Non-Par Fee
Diagnostic X-Ray & Lab	Up to \$200 per year		Up to \$200 per year		Up to \$200 per year	
	100%	Non-Par Fee	100%	Non-Par Fee	90%	Non-Par Fee
Psychiatric & Substance Abuse Inpatient Hospital (30 days/yr) Inpatient/Outpatient Professional	80% 50% to \$50	\$250 - \$270 per day 50% to \$25	COVERED THROUGH BHP 2000 (see attached benefit summary)		COVERED THROUGH BHP 2000 (see attached benefit summary)	
Office Visits	100%	Non-Par Fee	Ded Waived \$10 co-pay 100%	Non-Par Fee	Ded Waived \$30 co-pay 90%	Non-Par Fee
Hearing Aid (Up to \$1,000 every 36 months)	100%	Non-Par Fee	100%	Non-Par Fee	90%	Non-Par Fee
Physical Therapy (medically necessary)	100%	Non-Par Fee	100%	Non-Par Fee	90%	Non-Par Fee
Acupuncture	100%	Non-Par Fee	100%	Non-Par Fee	90%	Non-Par Fee
Durable Medical Equipment	100%	100% C&R	100%	100% C&R	90%	90% C&R
Hospice (\$10,000 maximum per member)	100%	100%	100%	100%	90%	90%
Ambulance	100%	100%	100%	100%	90%	90%
Home Health Care 100 visits/yr (prior authorization required)	100%	100%	100%	100%	90%	90%
Home Infusion	100%	100%/\$600 max	100%	100%/\$600 max	90%	90%/\$600 max
Chiropractic Services (26 visits per yr)	100% up to \$50 per visit	Non-Par Fee up to \$25 per visit	100% up to \$50 per visit	Non-Par Fee up to \$25 per visit	90% up to \$50 per visit	Non-Par Fee up to \$25 per visit
Outpatient Prescription Drugs	Retail	Mail	Retail	Mail	Retail	Mail
Supply RX Plan	30 days	90 days	30 days	90 days	30 days	90 days
	A		G		G	
			Plan G excludes 6, non-life sustaining, drug categories.		Plan G excludes 6, non-life sustaining, drug categories.	
Generic Drugs	\$5	\$10	\$5	\$10	\$7	\$14
Preferred Brand Name Drugs	\$10	\$20	\$20	\$50	\$25	\$60
Non-Preferred Brand Name Drugs	\$25	\$50	\$20	\$50	\$25	\$60
Lifetime Maximum	\$5,000,000		\$5,000,000		\$5,000,000	

Plans reflect 12thly rates

	40607A	40607C	40607D
Delta Dental PPO \$3,000 Annual Max w/ortho 100% pd. Max. \$3,000 Coverage for Adults and Children \$107.70 per Mo.	PB OPTION 1-A \$1,022.00 \$5 - \$10 - \$25	\$915.00 Plan G \$5-\$20 included BHP 2000 included	PBC 90%-C \$30 \$826.00 Plan G \$7-\$25 included BHP 2000 included
	DD 2000 Premier \$120.00 VSP \$0 Co-Pay P-C \$27.40	DD 2000 Premier \$120.00 VSP \$0 Co-Pay P-C \$27.40	DD 2000 Premier \$120.00 VSP \$0 Co-Pay P-C \$27.40
TOTAL PER EMP/MO	\$1,169.40	\$1,062.40	\$973.40
TOTAL PER EMP/YR	\$14,032.80	\$12,748.80	\$11,680.80
DISTRICT CAP	\$8,588.00	\$8,588.00	\$8,588.00
DIFFERENCE PER EMP/MO (12 mo pay)	\$453.73	\$346.73	\$257.73
DIFFERENCE PER EMP/YR	\$5,444.80	\$4,160.80	\$3,092.80

**High Deductible Plan
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HDHP-B NO HAS
40607G

Services	Participating Providers
Provider Network(s):	
Hospital	
Professional	
Calendar Year Deductible(s)	See Deductible Options
Annual Out-Of-Pocket Maximum	
<i>Includes Deductible, co-pays and co-insurance</i>	\$5,000 Per Individual \$10,000 Per Family
Lifetime Maximum	\$5,000,000
Inpatient Hospital <i>Room, Board & Support Services (prior authorization required)</i>	90%
Ambulatory Surgery Center	90%
Outpatient Hospital (non-emergency) <i>Facility Expenses:</i>	\$100 co-pay 90%
<i>Professional Expenses:</i>	90%
Surgeon & Anesthetist	90%
Preventive Care (age 0 - 25)	Deductible Waived
	\$25 co-pay per visit
Routine Exam (7 and older)	Deductible Waived
	\$25 co-pay per visit
Cancer Screening Test	90%, Deductible Waived
Diagnostic X-Ray & Lab	90%
Psychiatric & Substance Abuse Inpatient Hospital (30 days/yr) Inpatient/Outpatient Professional	90% 50% up to \$20
Office Visits	90%
Hearing Aid (Up to \$1,000 every 36 months)	90%
Physical Therapy (medically necessary)	Physical Therapy/Chiro Combines 12 visits per year
Acupuncture	12 visits per year 90% up to \$25 per visit
Durable Medical Equipment	90%
Hospice (\$10,000 maximum per member)	90%
Ambulance	90%
Home Health Care 100 visits/yr (prior authorization required)	90%
Chiropractic Services (26 visits per yr)	Physical Therapy/Chiro Combines 12 visits per year
Outpatient Prescription Drugs Administered by medical carrier Mail order pharmacy is available	90%

Option 1

HDHP-B2500/5000	
HD PPO	\$522.00
RX Included	\$0.00
BH Included	\$0.00
DD 2000 Premier	\$120.00
VSP \$0 Co-Pay F	\$27.40
	\$669.40
	\$8,032.80

	\$8,588.00
	-\$46.27
	-\$555.20

\$2,500/\$5,000 Deductible
\$2,500/\$5,000 Co-Insurance
90%
Rx&BH benefits & costs in Medical

Option 2
Delta Dental PPO \$3,000 Annual Max with Orthodontic
100% Paid Maximum \$3,000 Coverage for Adults
and Children.
\$107.70 per Month.