

March 1, 2010

**2009-2010 HEALTH CARE COVERAGE PLAN
COMPARABILITY PROGRAM COMPARISON**

San Elizario ISD

As required in the provisions of the Texas Education Code (TEC) Section 22.004 which was most recently amended by House Bill 2427 of the 80th Texas Legislature, San Elizario ISD has prepared this report to confirm the comparability of the health care coverage offered to its employees with HealthSelect coverage offered by the State of Texas to its employees.

This report is available for review at the Central Administrative Office of each campus and is posted on the District's website.

TEC Section 22.004 (d) identifies six Requirements that must be satisfied in this report.

REQUIREMENT 1

The Board of Trustees of San Elizario ISD on **May 21, 2009** adopted a resolution authorizing the District to self-insure the group health coverage for the District's employees. On an annual basis San Elizario ISD's auditors confirm that the District is adequately able to cover the assumed liability of the self-funded benefit plan. Under the Texas Public Information Act a copy of the most recent auditor's report can be obtained by contacting the San Elizario ISD.

REQUIREMENT 2

On **March 1, 2010** San Elizario ISD offered the following group health coverage benefit options. This is a summary description of benefits only. Refer to the actual benefit booklet for complete benefits, limitations and exclusions descriptions. The benefit offerings are subject to change in the future.

Plan Type	HDHP	Core Plan-PPO	Buy Up Plan-PPO
Deductible \$	2500 / 5000	500 / 1,000	250 / 500
Coinsurance %	100 / 80	80 / 50	90 / 50
Out of Pocket Max \$	2500/5000	2500/2500+/no limit	2000/2000+/no limit
Office Visit Co-pay\$	100% / 80% after Ded	25	20
ER Co-pay \$	100% / 80% after Ded	50	50
RX - 30 day \$ G/PB/NPB	10/30/50	10/30/50	5/25/45
RX- 90 day \$ G/PB/NPB	20 / 60 / 100	20 / 60 / 100	10 / 50 / 90
Hosp Ded \$	100% / 80% after Ded	100	100
Lifetime Max	\$1 Million	\$1 Million	\$1 Million
Preferred Hospital	Open Access	Open Access	Open Access

Highlighted Cells Indicate that copays only apply after deductible has been met and to preventive class prescription medications.

REQUIREMENT 3

On **March 1, 2010**, the amount paid by San Elizario ISD and by the District employees for the group health coverage options on this date are listed below. These amounts are subject to change in the future.

San Elizario ISD's Monthly Contribution per Employee: **\$270.00**

Monthly	High Deductible Health Plan	Core Plan	Buy Up Plan
Employee Only	\$0.00	\$35.00	\$87.00
Employee & Spouse	\$206.00	\$259.00	\$358.00
Employee & Child(ren)	\$173.00	\$223.00	\$308.00
Employee & Family	\$405.00	\$476.00	\$619.00

REQUIREMENT 4

On March 1, 2010, the estimated number of employees covered under the San Elizario ISD group health plan is **502**.

REQUIREMENT 5

As a prudent and conscientious employer and provider of employer sponsored benefits, San Elizario ISD was able to complete this report, as well as the required 2009-2010 Comparability Report Form which is on file with the Teacher Retirement System with minimal staff involvement and without difficulty.

REQUIREMENT 6

In order to determine comparability with the State of Texas HealthSelect plan, San Elizario ISD used the following approach.

Recognizing that the costs of health care can vary by region with the state of Texas, San Elizario ISD used the following frequencies of health claims utilization for a LOW, MEDIUM and HIGH Utilizer of health benefits and calculated the annual out of pocket expense for each of the benefit options available to San Elizario ISD's employees as well as the Health Select plan (a copy of this plan summary can be obtained at <http://www.bcbstx.com/hs/pdf/benefitbooks/090109u65.pdf>)

Type of Utilizer	LOW	MEDIUM	HIGH
Total Eligible Non Hospital Charges Subject to Deductible (non-co-pay related)	\$ 200.00	\$ 2,000.00	\$ 20,000.00
Primary Care Office Visits	2	6	12
Specialty Care Office Visits	0	3	12
Outpatient Procedures	1	1	2
Hospital Admissions	0	1	2
Inpatient Hospital Stay in Days	0	2	10
Total Inpatient Hospital Eligible Charges	\$ -	\$ 3,000.00	\$ 40,000.00
Emergency Room Visits	1	1	1
Generic Drug Scripts - 30 day supply	2	10	12
Preferred Drug Scripts - 30 day supply	2	10	24
Non Drug Scripts - 30 day supply	0	4	12

The estimated annual out of pocket expense to each utilizer for each plan is summarized below:

Low Utilizer	
Benefit Plan Option	Annual Out of Pocket Expense
San Elizario ISD Buy Up Plan	\$ 295.00
Health Select	\$ 350.00
San Elizario ISD Core Plan	\$ 360.00
San Elizario ISD CDHP	\$ 570.00

Medium Utilizer	
Benefit Plan Option	Annual Out of Pocket Expense
San Elizario ISD Buy Up Plan	\$ 1,355.00
Health Select	\$ 2,020.00
San Elizario ISD Core Plan	\$ 2,235.00
San Elizario ISD CDHP	\$ 2,500.00

High Utilizer	
Benefit Plan Option	Annual Out of Pocket Expense
San Elizario ISD CDHP	\$ 2,500.00
Health Select	\$ 3,800.00
San Elizario ISD Buy Up Plan	\$ 3,900.00
San Elizario ISD Core Plan	\$ 5,050.00

Each of the benefit plan options listed above is based upon a Preferred Provider Organization network of preferred health care providers that represent comparable access to quality health care providers for the plan members. Each plan offers a comprehensive plan design with benefits provided for physician, hospital and prescription drug services. Each plan includes reasonable limitations and exclusions based upon standard industry provisions used within health care benefit plans.

San Elizario ISD is satisfied that it offers one or more benefit options that are comparable to or better than the HealthSelect plan which is used as a benchmark for comparison purposes.

**SCHEDULE OF BENEFITS
MEDICAL BENEFITS
SAN ELIZARIO ISD
CORE PLAN**

GENERAL INFORMATION

BENEFIT	IN NETWORK	OUT OF NETWORK
Deductible	Individual - \$500 Family - \$1,000	Individual - \$1000 Family - \$2,000
	<ul style="list-style-type: none"> • In and Out of Network deductibles do not cross apply • Deductible carry forward for services rendered in 4th quarter • Members will receive credit for 2010 for deductible applied Oct 1 – Dec 31, 2009 	
Coinsurance Percentage	80% Unless otherwise specified	50% Unless otherwise specified
Coinsurance Limit	Individual - \$2,500 Family - \$7,500	Unlimited
	<ul style="list-style-type: none"> • In and Out of Network coinsurance limits do not cross apply 	
Lifetime Maximum Benefit	\$1,000,000	

COVERED SERVICES		
HOSPITAL & FACILITY		
BENEFIT	IN NETWORK	OUT OF NETWORK
Ambulatory Surgical Facility	80% after deductible	50% after deductible
	The following facilities are paid at the In Network level <ul style="list-style-type: none"> • Paso Del Norte Surgery Center: 74-2797719 • Endoscopy Center of El Paso: 62-1731682 • Paso Del Norte Endoscopy: 74-2772738 • El Paso Day Surgery: 20-0285362 • East El Paso Surgery: 62-1846494 • The Physicians Hospital (East El Paso Physicians Medical Center): 26-1281512 	
Birthing Center	Not covered	Not covered
Diagnostic Lab & X-ray Facility	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Preferred labs covered 100% no deductible or coinsurance <ul style="list-style-type: none"> ○ El Paso Pathology Laboratory ○ GYN Path Services ○ LabCorp ○ TriCore Reference Laboratories ○ Quest Diagnostics ○ Clinical Pathology Laboratories, Inc. 	
Emergency Room True Emergency	\$50 copay, 80% after deductible	\$50 copay, 80% after deductible
	\$50 copay, 50% after deductible	\$100 copay, 50% after deductible
	<ul style="list-style-type: none"> • Copay applied to facility charge • Waive copay if patient is admitted 	
Inpatient Hospital	\$100 per admission deductible 80% after annual deductible	\$750 per admission deductible 50% after annual deductible
	The following facilities are paid at the In Network level, without per admission deductible <ul style="list-style-type: none"> • Paso Del Norte Surgery Center: 74-2797719 • Endoscopy Center of El Paso: 62-1731682 • Paso Del Norte Endoscopy: 74-2772738 • El Paso Day Surgery: 20-0285362 • East El Paso Surgery: 62-1846494 • The Physicians Hospital (East El Paso Physicians Medical Center): 26-1281512 	
Inpatient Hospice Care	\$100 per admission deductible 80% after annual deductible	\$750 per admission deductible 50% after annual deductible
	<ul style="list-style-type: none"> • \$20,000 lifetime maximum per person, Inpatient and Outpatient combined 	
Mental Health & Substance Abuse Except Serious Mental Health	Inpatient	
	\$100 per admission deductible 80% after annual deductible	\$750 per admission deductible 50% after annual deductible
	<ul style="list-style-type: none"> • 30 days per person per benefit period • No substitutions 	
	Outpatient	
	Psychotherapy - \$25 copay, no ded or coins All other services – 80% after deductible	50% after deductible
<u>Covered Services</u> <ul style="list-style-type: none"> • Family/marital counseling • Biofeedback • Milieu/Situational therapy 	<ul style="list-style-type: none"> • 30 days per person per benefit period • Partial hospitalization and Intensive Outpatient (IOP) covered under Outpatient benefit • Medicine checks paid under Medical as Illness 	

<ul style="list-style-type: none"> Behavioral Disorders Developmental delay Autism ADD/ADHA 	Psychological Testing	
<p>Serious Mental Health Serious Mental Illness shall mean:</p> <ul style="list-style-type: none"> Schizophrenia Paranoid and other psychotic disorders Bipolar disorders (mixed, manic, and depressive) Major depressive disorders (single episode or recurrent) Schizo-affective disorders (bipolar or depressive) Pervasive developmental disorders Obsessive-compulsive disorders Depression in childhood and adolescence 	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> Psychological testing covered under Medical as Illness 	
	Inpatient	
	\$100 per admission deductible 80% after annual deductible	\$750 per admission deductible 50% after annual deductible
	<ul style="list-style-type: none"> 45 days per person per benefit period No substitutions 	
	Outpatient/Detox	
\$25 copay, no deductible or coinsurance	50% after deductible	
<ul style="list-style-type: none"> 60ys per person per benefit period combined with Outpatient Mental Health Partial hospitalization and Intensive Outpatient (IOP) covered under Outpatient benefit 		
<p>Routine Nursery Care of Newborn Infant</p>	\$100 per admission deductible 80% after annual deductible	\$750 per admission deductible 50% after annual deductible
<ul style="list-style-type: none"> Baby's bill not paid under Mother's bill 		
<p>Skilled Nursing Facility</p>	\$100 per admission deductible 80% after annual deductible	\$750 per admission deductible 50% after annual deductible
<ul style="list-style-type: none"> \$10,000 maximum per person per benefit period 		
<p>Transplant Services Facility charge</p> <p>See Surgical Services for surgeon benefits</p>	\$100 per admission deductible 80% after annual deductible	\$750 per admission deductible 50% after annual deductible
<ul style="list-style-type: none"> Covered procedures: <ul style="list-style-type: none"> Artery or vein Bone marrow Cornea Heart Heart/Lung Kidney Kidney/pancreas Liver Lung, single Pancreas Prosthetic lenses in connection with cataract surgery Prosthetic bypass or replacement vessels Stem cell transfer If donor and recipient are both participants in the Plan, donor charges are paid under the donor's account If donor is a participant and the recipient is not, donor charges are not covered 		

MEDICAL SERVICES		
BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Abortion Services	Not covered	Not covered
Acupuncture Services	Not covered	Not covered
Allergy Testing	80% after deductible	50% after deductible
Allergy Injections & Serum	80% after deductible	50% after deductible
Ambulance Services	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Patient must be transported. Any services rendered without transportation are not covered 	
Anesthesiologist Services	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • CRNA is a covered provider 	
Birth Control	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Injections • Depo Provera • Sterilization • Devices • Insertion of IUDs <p>**Removal of IUD is considered reversal of sterilization and is not covered</p>	
Cardiac Rehabilitation Therapy	80% after deductible	50% after deductible
Chemotherapy	80% after deductible	50% after deductible
Chiropractic Services	Manipulations/OV - \$25 copay, no ded or coins All other services – 80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • \$1,500 maximum per person per benefit period 	
Cosmetic/Reconstructive Surgery	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Correction of a congenital deformity visible at birth • Reconstructive surgery for treatment of an accidental injury to resort bodily function • Breast reconstruction following a mastectomy, including reconstruction of the other breast to create symmetrical appearance 	
Dental Services	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Correction of congenital abnormalities of jaw – if born under the plan • Excision of lesions • Incision of accessory sinus, mouth, salivary glands or ducts • Surgical removal of all impacted teeth <p>When the patient is covered under both Medical and Dental coverages, these services are paid under the Medical plan first and the balance is paid under the Dental plan.</p> <p>If the member only has Dental coverage, these services are covered under the Dental plan.</p>	
Diagnostic Lab & X-ray Physician's Office	80% no deductible	50% after deductible
Includes preadmission testing	<ul style="list-style-type: none"> • Preferred labs covered 100% no deductible or coinsurance <ul style="list-style-type: none"> ○ El Paso Pathology Laboratory ○ GYN Path Services ○ LabCorp ○ TriCore Reference Laboratories ○ Quest Diagnostics ○ Clinical Pathology Laboratories, Inc. 	
Durable Medical Equipment	80% no deductible	50% after deductible
	<ul style="list-style-type: none"> • Repair and routine maintenance covered • Replacement covered if necessary due to participant's growth and development 	
Education Services	80% no deductible	50% after deductible

Hearing Tests & Hearing Aids (Non routine)	Not covered	Not covered
Hemodialysis	80% after deductible	50% after deductible
Home Health Care Services	80% no deductible	50% after deductible
	<ul style="list-style-type: none"> • \$10,000 maximum per person per benefit period 	
Hospice Services Outpatient	80% no deductible	50% after deductible
	<ul style="list-style-type: none"> • \$20,000 lifetime maximum per person • Respite care and Bereavement counseling not covered 	
Infertility Services	Not covered	Not covered
Maternity Services	80% no deductible	50% after deductible
	<ul style="list-style-type: none"> • All female participants • Initial OV and Urinalysis covered separately like non routine OV and lab. All remaining pre and post natal visits and urinalysis should be billed along with the delivery fee. Will be denied if billed separately. • 2 ultrasounds allowed for uncomplicated pregnancy, no limit for complicated pregnancy • Dr Harlass – only Perinatologist in the area. Does not perform deliveries. Visits and urinalysis will be billed independently from the delivery fee and allowed. 	
Medical and Surgical Supplies	80% no deductible	50% after deductible
	<ul style="list-style-type: none"> • Surgical stockings not covered 	
Morbid Obesity	Not covered	Not covered
	<ul style="list-style-type: none"> • This includes surgical correction for Morbid Obesity 	
Occupational Therapy	80% after deductible	50% after deductible
Orthotics (Back, knee, neck, wrist, etc)	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Must be prescribed by a network physician 	
Orthopedic Shoe & Foot Orthotics	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Must be prescribed by a network physician 	
Physical Medicine	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Services performed in office setting • CPTs 97010 – 97799 • \$1,500 maximum per person per calendar year 	
Physical Therapy	80% after deductible	50% after deductible
Physician Office Visits for Non-Routine Care	OV - \$25 copay, no ded or coins All other services – 80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • B-12 covered for pernicious anemia and Crohn's disease • Night Clinic, Northeast Cornerstone Pediatric - \$85 paid for CPTs 99050 & 99058, patient is not responsible for copay. <ul style="list-style-type: none"> ○ TIN's – 205406356, 752977867, 260114759, 200418051, 020570015, 820582822 	
Physician Visits During IP Hospital/SNF Confinement	80% after deductible	50% after deductible
Podiatry Services	OV - \$25 copay, no ded or coins All other services - 80% after deductible	50% after deductible
Preadmission Testing	80% after deductible	50% after deductible
Preventive Care Adult Age 2 and older	OV - \$25 copay, no ded or coins All other services – 100%, no ded or coins	50% after deductible

	<ul style="list-style-type: none"> • 1 routine colon/rectal cancer screen per benefit period • 1 routine ovarian cancer screen (CA-125) per benefit period • 1 routine prostate cancer screen (PSA) per benefit period • 1 routine pap smear per benefit period • 1 routine mammogram – no age limitation • 1 routine physical exam per benefit period • 1 routine gynecological exam per benefit period in additional to Physical exam • 1 routine hearing exam per benefit period • 1 routine vision exam per benefit period • Routine immunizations – no limitations • 1 routine bone density scan per benefit period 	
Preventive Care Baby Birth to age 2	OV - \$25 copay, no ded or coins	50% after deductible
	All other services – 100%, no ded or coins	
	<ul style="list-style-type: none"> • Routine physical exam • Routine lab work • Routine immunizations • Routine hearing and vision 	
Private Duty Nursing Services	Not covered	Not covered
Prosthetic Appliances	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Repair and routine maintenance covered • Replacement covered if necessary due to participant's growth and development 	
Radiation Therapy	80% after deductible	50% after deductible
Respiratory Therapy	80% after deductible	50% after deductible
Second and Third Surgical Opinion	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Voluntary, may be requested by Medical Case Manager 	
Sleep Disorder/Sleep Study	80% after deductible	50% after deductible
Smoking Cessation	Not covered	Not covered
Speech Therapy	80% after deductible	50% after deductible
Surgical Services	Surgeon	80% after deductible
	Surgical Assistant	20% of primary surgeon's fee
	Multiple Surgeries	First surgery – 100% Second surgery – 50% Third & subsequent surgeries – 50%
TMJ Treatment	Not covered	Not covered
Urgent Care Free standing	OV - \$25 copay, no ded or coins	50% after deductible
	All other services – 80% after deductible	
Vision Services (Non routine)	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Covered for accident, medical or injury 	
Wigs	Not covered	Not covered
Wellness/Gym Benefit – Health 15	<p>All members are eligible. The following information must be supplied to receive \$15 per month reimbursement:</p> <ul style="list-style-type: none"> • Assessment through Life Care Center • Completed application form for reimbursement – copies can be obtained via employer HR department or www.healthscopebenefits.com • Attend 8 times per month for 6 consecutive months – proof from facility required • Receipt or proof of payment 	

**PRESCRIPTION DRUG
SCHEDULE OF BENEFITS**

	Retail Pharmacy 30 Day Supply	Mail Order Pharmacy 90 Day Supply
Generic Drug	\$10 copay	\$0 copay
Preferred Brand Name Drug	\$30 copay	\$60 copay
Non-Preferred Brand Name Drug	\$50 copay	\$80 copay
Notes	<ul style="list-style-type: none"> • Penalty for using a non participating pharmacy – Rx paid at 65% after deductible • DAW Requirement – If Brand Rx is purchased when a Generic Rx is available, the member must pay the difference between the Brand Rx and Generic Rx price plus the copay 	

**SCHEDULE OF BENEFITS
MEDICAL BENEFITS
SAN ELIZARIO ISD
CDHP**

GENERAL INFORMATION

BENEFIT	IN NETWORK	OUT OF NETWORK
Deductible	Individual - \$2,500 Family - \$5,000	
	<ul style="list-style-type: none"> • In and Out of Network deductibles do not cross apply • Deductible carryforward does not apply 	
Coinsurance Percentage	100% Unless otherwise specified	80% Unless otherwise specified
Coinsurance Limit	\$0	Unlimited
	<ul style="list-style-type: none"> • Patient is only responsible for the deductible when services are performed by a participating provider. • Patient is responsible for the deductible and/or 20% for all service performed by a non-participating provider. 	
Lifetime Maximum Benefit	\$1,000,000	

COVERED SERVICES		
HOSPITAL & FACILITY		
BENEFIT	IN NETWORK	OUT OF NETWORK
Ambulatory Surgical Facility	100% after deductible	80% after deductible
	The following facilities are paid at the In Network level <ul style="list-style-type: none"> • Paso Del Norte Surgery Center: 74-2797719 • Endoscopy Center of El Paso: 62-1731682 • Paso Del Norte Endoscopy: 74-2772738 • El Paso Day Surgery: 20-0285362 • East El Paso Surgery: 62-1846494 • The Physicians Hospital (East El Paso Physicians Medical Center): 26-1281512 	
Birthing Center	Not covered	Not covered
Diagnostic Lab & X-ray Facility	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Preferred labs covered <ul style="list-style-type: none"> ○ El Paso Pathology Laboratory ○ GYN Path Services ○ LabCorp ○ TriCore Reference Laboratories ○ Quest Diagnostics ○ Clinical Pathology Laboratories, Inc. 	
Emergency Room	100% after deductible	80% after deductible
Inpatient Hospital	100% after annual deductible	80% after annual deductible
	The following facilities are paid at the In Network level <ul style="list-style-type: none"> • Paso Del Norte Surgery Center: 74-2797719 • Endoscopy Center of El Paso: 62-1731682 • Paso Del Norte Endoscopy: 74-2772738 • El Paso Day Surgery: 20-0285362 • East El Paso Surgery: 62-1846494 • The Physicians Hospital (East El Paso Physicians Medical Center): 26-1281512 	
Inpatient Hospice Care	100% after annual deductible	80% after annual deductible
	<ul style="list-style-type: none"> • \$20,000 lifetime maximum per person, Inpatient and Outpatient combined 	
Mental Health & Substance Abuse Except Serious Mental Health	Inpatient	
	100% after annual deductible	80% after annual deductible
	<ul style="list-style-type: none"> • 30 days per person per benefit period • No substitutions 	
	Outpatient	
	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • 30 days per person per benefit period • Partial hospitalization and Intensive Outpatient (IOP) covered under Outpatient benefit • Medicine checks paid under Medical as Illness 	
	Psychological Testing	
100% after deductible	80% after deductible	
<ul style="list-style-type: none"> • Psychological testing covered under Medical as Illness 		
Serious Mental Health	Inpatient	

<p>Serious Mental Illness shall mean:</p> <ul style="list-style-type: none"> • Schizophrenia • Paranoid and other psychotic disorders • Bipolar disorders (mixed, manic, and depressive) • Major depressive disorders (single episode or recurrent) • Schizo-affective disorders (bipolar or depressive) • Pervasive developmental disorders • Obsessive-compulsive disorders • Depression in childhood and adolescence 	100% after annual deductible	80% after annual deductible
	<ul style="list-style-type: none"> • 45 days per person per benefit period • No substitutions 	
	Outpatient/Detox	
	100% after annual deductible	80% after annual deductible
	<ul style="list-style-type: none"> • 60ys per person per benefit period combined with Outpatient Mental Health • Partial hospitalization and Intensive Outpatient (IOP) covered under Outpatient benefit 	
Routine Nursery Care of Newborn Infant	100% after annual deductible	80% after annual deductible
	<ul style="list-style-type: none"> • Baby's bill not paid under Mother's bill 	
Skilled Nursing Facility	100% after annual deductible	80% after annual deductible
	<ul style="list-style-type: none"> • \$10,000 maximum per person per benefit period 	
<p>Transplant Services Facility charge</p> <p>See Surgical Services for surgeon benefits</p>	100% after annual deductible	80% after annual deductible
	<ul style="list-style-type: none"> • Covered procedures: <ul style="list-style-type: none"> ○ Artery or vein ○ Bone marrow ○ Cornea ○ Heart ○ Heart/Lung ○ Kidney ○ Kidney/pancreas ○ Liver ○ Lung, single ○ Pancreas ○ Prosthetic lenses in connection with cataract surgery ○ Prosthetic bypass or replacement vessels ○ Stem cell transfer • If donor and recipient are both participants in the Plan, donor charges are paid under the donor's account • If donor is a participant and the recipient is not, donor charges are not covered 	

MEDICAL SERVICES		
BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Abortion Services	Not covered	Not covered
Acupuncture Services	Not covered	Not covered
Allergy Testing	100% after deductible	80% after deductible
Allergy Injections & Serum	100% after deductible	80% after deductible
Ambulance Services	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Patient must be transported. Any services rendered without transportation are not covered 	
Anesthesiologist Services	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • CRNA is a covered provider 	
Birth Control	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Injections • Depo Provera • Sterilization • Devices • Insertion of IUDs <p>**Removal of IUD is considered reversal of sterilization and is not covered</p>	
Cardiac Rehabilitation Therapy	100% after deductible	80% after deductible
Chemotherapy	100% after deductible	80% after deductible
Chiropractic Services	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • \$1,500 maximum per person per benefit period 	
Cosmetic/Reconstructive Surgery	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Correction of a congenital deformity visible at birth • Reconstructive surgery for treatment of an accidental injury to resort bodily function • Breast reconstruction following a mastectomy, including reconstruction of the other breast to create symmetrical appearance 	
Dental Services	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Correction of congenital abnormalities of jaw – if born under the plan • Excision of lesions • Incision of accessory sinus, mouth, salivary glands or ducts • Surgical removal of all impacted teeth <p>When the patient is covered under both Medical and Dental coverages, these services are paid under the Medical plan first and the balance is paid under the Dental plan.</p> <p>If the member only has Dental coverage, these services are covered under the Dental plan.</p>	
Diagnostic Lab & X-ray Physician's Office	100% after deductible	80% after deductible
Includes preadmission testing	<ul style="list-style-type: none"> • Preferred labs covered <ul style="list-style-type: none"> ○ El Paso Pathology Laboratory ○ GYN Path Services ○ LabCorp ○ TriCore Reference Laboratories ○ Quest Diagnostics ○ Clinical Pathology Laboratories, Inc. 	
Durable Medical Equipment	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Repair and routine maintenance covered • Replacement covered if necessary due to participant's growth and development 	
Education Services	100% after deductible	80% after deductible

Hearing Tests & Hearing Aids (Non routine)	Not covered	Not covered
Hemodialysis	100% after deductible	80% after deductible
Home Health Care Services	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • \$10,000 maximum per person per benefit period 	
Hospice Services Outpatient	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • \$20,000 lifetime maximum per person • Respite care and Bereavement counseling not covered 	
Infertility Services	Not covered	Not covered
Maternity Services	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • All female participants • Initial OV and Urinalysis covered separately like non routine OV and lab. All remaining pre and post natal visits and urinalysis should be billed along with the delivery fee. Will be denied if billed separately. • 2 ultrasounds allowed for uncomplicated pregnancy, no limit for complicated pregnancy • Dr Harlass – only Perinatologist in the area. Does not perform deliveries. Visits and urinalysis will be billed independently from the delivery fee and allowed. 	
Medical and Surgical Supplies	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Surgical stockings not covered 	
Morbid Obesity	Not covered	Not covered
	<ul style="list-style-type: none"> • This includes surgical correction for Morbid Obesity 	
Occupational Therapy	100% after deductible	80% after deductible
Orthotics (Back, knee, neck, wrist, etc)	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Must be prescribed by a network physician 	
Orthopedic Shoe & Foot Orthotics	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Must be prescribed by a network physician 	
Physical Medicine	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Services performed in office setting • CPTs 97010 – 97799 • \$1,500 maximum per person per calendar year 	
Physical Therapy	100% after deductible	80% after deductible
Physician Office Visits for Non-Routine Care	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • B-12 covered for pernicious anemia and Crohn's disease • Night Clinic, Northeast Cornerstone Pediatric - \$85 paid for CPTs 99050 & 99058, patient is not responsible for copay. <ul style="list-style-type: none"> ◦ TIN's – 205406356, 752977867, 260114759, 200418051, 020570015, 820582822 	
Physician Visits During IP Hospital/SNF Confinement	100% after deductible	80% after deductible
Podiatry Services	100% after deductible	80% after deductible
Preadmission Testing	100% after deductible	80% after deductible
Prescription Drugs	100% after deductible	100% after deductible
Preventive Care Adult	\$25 copay	50% after deductible

Age 2 and older	<ul style="list-style-type: none"> • \$500 maximum per person per benefit period • 1 routine colon/rectal cancer screen per benefit period • 1 routine ovarian cancer screen (CA-125) per benefit period • 1 routine prostate cancer screen (PSA) per benefit period • 1 routine pap smear per benefit period • 1 routine mammogram – no age limitation • 1 routine physical exam per benefit period • 1 routine gynecological exam per benefit period in additional to Physical exam • 1 routine hearing exam per benefit period • 1 routine vision exam per benefit period • Routine immunizations – no limitations • 1 routine bone density scan per benefit period 	
Preventive Care Baby Birth to age 2	\$25 copay	50% after deductible
	<ul style="list-style-type: none"> • \$500 maximum per person per benefit period • Routine physical exam • Routine lab work • Routine immunizations • Routine hearing and vision 	
Private Duty Nursing Services	Not covered	Not covered
Prosthetic Appliances	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Repair and routine maintenance covered • Replacement covered if necessary due to participant's growth and development 	
Radiation Therapy	100% after deductible	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Second and Third Surgical Opinion	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Voluntary, may be requested by Medical Case Manager 	
Sleep Disorder/Sleep Study	100% after deductible	80% after deductible
Smoking Cessation	Not covered	Not covered
Speech Therapy	100% after deductible	80% after deductible
Surgical Services	Surgeon	100% after deductible
	Surgical Assistant	25% of primary surgeon's fee
	Multiple Surgeries	First surgery – 100% Second surgery – 50% Third & subsequent surgeries – 50%
TMJ Treatment	Not covered	Not covered
Urgent Care Free standing	100% after deductible	80% after deductible
Vision Services (Non routine)	100% after deductible	80% after deductible
	<ul style="list-style-type: none"> • Covered for accident, medical or injury 	
Wigs	Not covered	Not covered
Wellness/Gym Benefit – Health 15	<p>All members are eligible. The following information must be supplied to receive \$15 per month reimbursement:</p> <ul style="list-style-type: none"> • Assessment through Life Care Center • Completed application form for reimbursement – copies can be obtained via employer HR department or www.healthscopebenefits.com • Attend 8 times per month for 6 consecutive months – proof from facility required • Receipt or proof of payment 	

**PRESCRIPTION DRUG
SCHEDULE OF BENEFITS**

	Retail Pharmacy 30 Day Supply	Mail Order Pharmacy 90 Day Supply
Generic Drug	\$10 copay/100% after deductible satisfied	\$20 copay/100% after deductible satisfied
Preferred Brand Name Drug	\$30 copay/ 100% after deductible satisfied	\$60 copay/100% after deductible satisfied
Non-Preferred Brand Name Drug	\$50 copay/100% after deductible satisfied	\$100 copay/100% after deductible satisfied
Notes	<ul style="list-style-type: none"> • Penalty for using a non participating pharmacy – Rx not covered • Chronic Drugs only have copay benefits • Copay applies to deductible and once deductible is satisfied, no more copay is taken • DAW Requirement – If Brand Rx is purchased when a Generic Rx is available, the member must pay the difference between the Brand Rx and Generic Rx price plus the copay 	

**SCHEDULE OF BENEFITS
MEDICAL BENEFITS
SAN ELIZARIO ISD
BUY UP PLAN**

GENERAL INFORMATION

BENEFIT	IN NETWORK	OUT OF NETWORK
Deductible	Individual - \$250 Family - \$400	Individual - \$700 Family - \$2,000
	<ul style="list-style-type: none"> • In and Out of Network deductibles do not cross apply • Deductible carry forward for services rendered in 4th quarter • Members will receive credit for 2010 for deductible applied Oct 1 – Dec 31, 2009 	
Coinsurance Percentage	90% Unless otherwise specified	50% Unless otherwise specified
Coinsurance Limit	Individual - \$2,000 Family - \$6,000	Unlimited
	<ul style="list-style-type: none"> • In and Out of Network coinsurance limits do not cross apply 	
Lifetime Maximum Benefit	\$1,000,000	

COVERED SERVICES		
HOSPITAL & FACILITY		
BENEFIT	IN NETWORK	OUT OF NETWORK
Ambulatory Surgical Facility	90% after deductible	50% after deductible
	The following facilities are paid at the In Network level <ul style="list-style-type: none"> • Paso Del Norte Surgery Center: 74-2797719 • Endoscopy Center of El Paso: 62-1731682 • Paso Del Norte Endoscopy: 74-2772738 • El Paso Day Surgery: 20-0285362 • East El Paso Surgery: 62-1846494 • The Physicians Hospital (East El Paso Physicians Medical Center): 26-1281512 	
Birthing Center	Not covered	Not covered
Diagnostic Lab & X-ray Facility Includes preadmission testing	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Preferred labs covered 100% no deductible or coinsurance <ul style="list-style-type: none"> ○ El Paso Pathology Laboratory ○ GYN Path Services ○ LabCorp ○ TriCore Reference Laboratories ○ Quest Diagnostics ○ Clinical Pathology Laboratories, Inc. 	
Emergency Room True Emergency Non Emergency	\$50 copay, 90% after deductible	\$50 copay, 80% after deductible
	\$50 copay, 50% after deductible	\$100 copay, 50% after deductible
	<ul style="list-style-type: none"> • Copay applied to facility charge • Waive copay if patient is admitted 	
Inpatient Hospital	\$100 per admission deductible 90% after annual deductible	\$750 per admission deductible 50% after annual deductible
	The following facilities are paid at the In Network level, without per admission deductible <ul style="list-style-type: none"> • Paso Del Norte Surgery Center: 74-2797719 • Endoscopy Center of El Paso: 62-1731682 • Paso Del Norte Endoscopy: 74-2772738 • El Paso Day Surgery: 20-0285362 • East El Paso Surgery: 62-1846494 • The Physicians Hospital (East El Paso Physicians Medical Center): 26-1281512 	
Inpatient Hospice Care	\$100 per admission deductible 90% after annual deductible	\$750 per admission deductible 50% after annual deductible
	<ul style="list-style-type: none"> • \$20,000 lifetime maximum per person, combined Inpatient and Outpatient • Respite care and Bereavement counseling not covered 	
Mental Health & Substance Abuse Except Serious Mental Health <u>Covered Providers</u> <ul style="list-style-type: none"> • Psychiatrist • Psychologist • Social Worker <u>Covered Services</u>	Inpatient	
	\$100 per admission deductible 90% after annual deductible	\$750 per admission deductible 50% after annual deductible
	<ul style="list-style-type: none"> • 30 days per person per benefit period • No substitutions 	
	Outpatient	
	Psychotherapy - \$20 copay, no ded or coins All other services – 90% after deductible	50% after deductible

<ul style="list-style-type: none"> Family/marital counseling Biofeedback Milieu/Situational therapy Behavioral Disorders Developmental delay Autism ADD/ADHA 	<ul style="list-style-type: none"> 30 days per person per benefit period Partial hospitalization and Intensive Outpatient (IOP) covered under Outpatient benefit Medicine checks paid under Medical as Illness 	
	Psychological Testing	
	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> Psychological testing covered under Medical as Illness 	
Serious Mental Health Serious Mental Illness shall mean: <ul style="list-style-type: none"> Schizophrenia Paranoid and other psychotic disorders Bipolar disorders (mixed, manic, and depressive) Major depressive disorders (single episode or recurrent) Schizo-affective disorders (bipolar or depressive) Pervasive developmental disorders Obsessive-compulsive disorders Depression in childhood and adolescence 	Inpatient	
	\$100 per admission deductible 90% after annual deductible	\$750 per admission deductible 50% after annual deductible
	<ul style="list-style-type: none"> 45 days per person per benefit period No substitutions 	
	Outpatient	
	\$20 copay, no deductible or coinsurance	50% after deductible
	<ul style="list-style-type: none"> 60ys per person per benefit period combined with Outpatient Mental Health Partial hospitalization and Intensive Outpatient (IOP) covered under Outpatient benefit 	
Routine Nursery Care of Newborn Infant	\$100 per admission deductible 90% after annual deductible	\$750 per admission deductible 50% after annual deductible
	<ul style="list-style-type: none"> Baby's bill not paid under Mother's bill 	
Skilled Nursing Facility	\$100 per admission deductible 90% after annual deductible	\$750 per admission deductible 50% after annual deductible
	<ul style="list-style-type: none"> \$10,000 maximum per person per benefit period 	
Transplant Services Facility charge	\$100 per admission deductible 90% after annual deductible	\$750 per admission deductible 50% after annual deductible

See **Surgical Services** for surgeon benefits

- Covered procedures:
 - Artery or vein
 - Bone marrow
 - Cornea
 - Heart
 - Heart/Lung
 - Kidney
 - Kidney/pancreas
 - Liver
 - Lung, single
 - Pancreas
 - Prosthetic lenses in connection with cataract surgery
 - Prosthetic bypass or replacement vessels
 - Stem cell transfer
- If donor and recipient are both participants in the Plan, donor charges are paid under the donor's account
- If donor is a participant and the recipient is not, donor charges are not covered

MEDICAL SERVICES		
BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Abortion Services	Not covered	Not covered
Acupuncture Services	Not covered	Not covered
Allergy Testing	90% after deductible	50% after deductible
Allergy Injections & Serum	90% after deductible	50% after deductible
Ambulance Services	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Patient must be transported. Any services rendered without transportation are not covered 	
Anesthesiologist Services	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • CRNA is a covered provider 	
Birth Control	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Injections • Depo Provera • Sterilization • Devices • Insertion of IUDs <p>**Removal of IUD is considered reversal of sterilization and is not covered</p>	
Cardiac Rehabilitation Therapy	90% after deductible	50% after deductible
Chemotherapy	90% after deductible	50% after deductible
Chiropractic Services	Manipulations/OV - \$20 copay, no ded or coins All other services – 90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • \$1,500 maximum per person per benefit period 	
Cosmetic/Reconstructive Surgery	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Correction of a congenital deformity visible at birth • Reconstructive surgery for treatment of an accidental injury to resort bodily function • Breast reconstruction following a mastectomy, including reconstruction of the other breast to create symmetrical appearance 	
Dental Services	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Correction of congenital abnormalities of jaw – if born under the plan • Excision of lesions • Incision of accessory sinus, mouth, salivary glands or ducts • Surgical removal of all impacted teeth <p>When the patient is covered under both Medical and Dental coverages, these services are paid under the Medical plan first and the balance is paid under the Dental plan.</p> <p>If the member only has Dental coverage, these services are covered under the Dental plan.</p>	
Diagnostic Lab & X-ray Physician's Office	90% no deductible	50% after deductible
Includes preadmission testing	<ul style="list-style-type: none"> • Preferred labs covered 100% no deductible or coinsurance <ul style="list-style-type: none"> ○ El Paso Pathology Laboratory ○ GYN Path Services ○ LabCorp ○ TriCore Reference Laboratories ○ Quest Diagnostics ○ Clinical Pathology Laboratories, Inc. 	
Durable Medical Equipment	90% no deductible	50% after deductible
	<ul style="list-style-type: none"> • Repair and routine maintenance covered • Replacement covered if necessary due to participant's growth and development 	
Education Services	90% no deductible	50% after deductible

Hearing Tests & Hearing Aids (Non routine)	Not covered	Not covered
Hemodialysis	90% after deductible	50% after deductible
Home Health Care Services	90% no deductible	50% after deductible
	<ul style="list-style-type: none"> • \$10,000 maximum per person per benefit period 	
Hospice Services Outpatient	90% no deductible	50% after deductible
	<ul style="list-style-type: none"> • \$20,000 lifetime maximum per person, combined Inpatient and Outpatient • Respite care and Bereavement counseling not covered 	
Infertility Services	Not covered	Not covered
Maternity Services	90% no deductible	50% after deductible
	<ul style="list-style-type: none"> • All female participants • Initial OV and Urinalysis covered separately like non routine OV and lab. All remaining pre and post natal visits and urinalysis should be billed along with the delivery fee. Will be denied if billed separately. • 2 ultrasounds allowed for uncomplicated pregnancy, no limit for complicated pregnancy • Dr Harlass – only Perinatologist in the area. Does not perform deliveries. Visits and urinalysis will be billed independently from the delivery fee and allowed. 	
Medical and Surgical Supplies	90% no deductible	50% after deductible
	<ul style="list-style-type: none"> • Surgical stockings not covered 	
Morbid Obesity	Not covered	Not covered
	<ul style="list-style-type: none"> • This includes surgical correction for Morbid Obesity 	
Occupational Therapy	90% after deductible	50% after deductible
Orthotics (Back, knee, neck, wrist, etc)	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Must be prescribed by a network physician 	
Orthopedic Shoe & Foot Orthotics	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Must be prescribed by a network physician 	
Physical Medicine	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Services performed in office setting • CPTs 97010 – 97799 • \$1,500 maximum per person per calendar year 	
Physical Therapy	90% after deductible	50% after deductible
Physician Office Visits for Non-Routine Care	OV - \$20 copay, no ded or coins All other services – 90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • B-12 covered for pernicious anemia and Crohn's disease • Night Clinic, Northeast Cornerstone Pediatric - \$85 paid for CPTs 99050 & 99058, patient is not responsible for copay. <ul style="list-style-type: none"> ○ TIN's – 205406356, 752977867, 260114759, 200418051, 020570015, 820582822 	
Physician Visits During IP Hospital/SNF Confinement	90% after deductible	50% after deductible
Podiatry Services	OV - \$20 copay, no ded or coins 90% after deductible	50% after deductible
Preadmission Testing	90% after deductible	50% after deductible
Preventive Care Adult Age 2 and older	OV - \$20 copay, no ded or coins All other services – 100%, no ded no coins	50% after deductible

	<ul style="list-style-type: none"> • 1 routine colon/rectal cancer screen per benefit period • 1 routine ovarian cancer screen (CA-125) per benefit period • 1 routine prostate cancer screen (PSA) per benefit period • 1 routine pap smear per benefit period • 1 routine mammogram – no age limitation • 1 routine physical exam per benefit period • 1 routine gynecological exam per benefit period in addition to the Physical Exam • 1 routine hearing exam per benefit period • 1 routine vision exam per benefit period • Routine immunizations – no limitations • 1 routine bone density scan per benefit period 	
Preventive Care Baby Birth to age 2	OV - \$20 copay, no ded or coins All other services – 100%, no ded no coins	50% after deductible
	<ul style="list-style-type: none"> • Routine physical exam • Routine lab work • Routine immunizations • Routine hearing and vision 	
Private Duty Nursing Services	Not covered	Not covered
Prosthetic Appliances	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Repair and routine maintenance covered • Replacement covered if necessary due to participant's growth and development 	
Radiation Therapy	90% after deductible	50% after deductible
Respiratory Therapy	90% after deductible	50% after deductible
Second and Third Surgical Opinion	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Voluntary, may be requested by Medical Case Manager 	
Sleep Disorder/Sleep Study	90% after deductible	50% after deductible
Smoking Cessation	Not covered	Not covered
Speech Therapy	90% after deductible	50% after deductible
Surgical Services	Surgeon	90% after deductible
	Surgical Assistant	20% of primary surgeon's fee
	Multiple Surgeries	First surgery – 100% Second surgery – 50% Third & subsequent surgeries – 50%
TMJ Treatment	Not covered	Not covered
Urgent Care Free standing	OV - \$20 copay, no ded or coins All other services – 90% after deductible	50% after deductible
	90% after deductible	50% after deductible
Vision Services (Non routine)	90% after deductible	50% after deductible
	<ul style="list-style-type: none"> • Covered for accident, medical or injury 	
Wigs	Not covered	Not covered
Wellness/Gym Benefit – Health 15	<p>All members are eligible. The following information must be supplied to receive \$15 per month reimbursement:</p> <ul style="list-style-type: none"> • Assessment through Life Care Center • Completed application form for reimbursement – copies can be obtained via employer HR department or www.healthscopebenefits.com • Attend 8 times per month for 6 consecutive months – proof from facility required • Receipt or proof of payment 	

**PRESCRIPTION DRUG
SCHEDULE OF BENEFITS**

	Retail Pharmacy 30 Day Supply	Mail Order Pharmacy 90 Day Supply
Generic Drug	\$5 copay	\$0 copay
Preferred Brand Name Drug	\$25 copay	\$50 copay
Non-Preferred Brand Name Drug	\$45 copay	\$70 copay
Notes	<ul style="list-style-type: none"> • Penalty for using a non participating pharmacy – Rx paid at 65% after deductible • DAW Requirement – If Brand Rx is purchased when a Generic Rx is available, the member must pay the difference between the Brand Rx and Generic Rx price plus the copay 	

SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT

&
HEALTHSCOPE BENEFITS

MONTHLY HEALTH PLAN RATES
2009-2010

HDHP

Employee Only	\$0.00	{ \$2500.00 Indv. Deductible/\$5000.00 Fam. Ded.
Employee Spouse	\$205.70	Preventive Care up to \$500.00 not subject to
Employee Child(ren)	\$172.70	deductible, Chronic Drugs-copay benefits,
Employee Family	\$404.80	Eligible for a Tax Exempt Health Savings Account (HSA)

Core Plan

Employee Only	\$35.00	
Employee Spouse	\$259.21	{ \$500.00 Yearly Deductible-80%/20%
Employee Child(ren)	\$223.24	\$25.00 co-pay
Employee Family	\$476.23	Medications-Generics\$10,Preferred\$30,Brand\$50

Buy up Plan

Employee Only	\$87.21	
Employee Spouse	\$358.18	{ \$250.00 Yearly Deductible-90%/10%
Employee Child(ren)	\$308.46	\$20.00 co-pay
Employee Family	\$619.21	Medications-Generics\$5,Preferred\$25,Brand\$45

MONTHLY DENTAL PLAN RATES

Core Plan

		Individual Calendar Year Deductible-	\$50.00
Employee Only	\$21.00	Family Calendar Year Deductible-	\$150.00 (3 or more members)
Employee Child(ren)	\$47.50	Preventive Treatment	100%, deductible waived
Employee Spouse	\$37.75	Basic Treatment	80% after deductible
Employee Family	\$56.00	Annual Maximum	\$2000.00

Buy Up Plan

Employee Only	\$25.50	Individual Calendar Year Deductible	\$50.00
Employee Child(ren)	\$62.00	Family Calendar Year Deductible	\$150.00 (3 or more members)
Employee Spouse	\$50.00	Preventive Treatment	100% deductible waived
Employee Family	\$75.50	Basic Treatment	80% after deductible
		Major Treatment	50% after deductible
		Orthodontic Annual Maximum	\$500.00
		Orthodontic Lifetime Maximum	\$1000.00
		Annual Maximum	\$2000.00

MONTHLY VISION PLAN RATES

Employee Only	\$7.15
Employee + 1	\$13.25
Employee Family	\$19.40

Benefit Summary:

Calendar Year Deductible-	None
Single vision lenses-	100% in any 12 consecutive months
Eye Examination-	Up to \$45.00 max in any 12 consecutive months
Bifocal lenses-	100% in any 12 consecutive months
Trifocal lenses-	100% in any 12 consecutive months
Progressive lenses-	Up to \$60.00 max in any 12 consecutive months
Lenticular lenses-	Up to \$96.00 max in any 12 consecutive months
Frames-	Up to \$85.00 max in any 12 consecutive months
(Maximum amounts include the cost of tinting, photograying and hardening of lenses)	
Contact Lenses	Up to \$100.00 in any 12 consecutive months
Laser Vision Correction	\$250.00 per eye. This is a one-time benefit.