

Memorandum of Understanding

This Memorandum of Understanding is entered into this 31 day of May 2016, by and between the Wayne Trace Board of Education (hereinafter "Board") and the Wayne Trace Education Association (hereinafter "Association").

WHEREAS, the parties have a mutual interest in providing the best medical, vision, life, and dental insurance to the bargaining unit members as well as providing the district with cost saving measures:

WHEREAS, the Collective Bargaining Agreement specifies: "The level of coverage provided for either family or single plans shall meet or exceed the current level of benefits in effect as of July 1, 2004".

NOW THEREFORE, the Board and the Association agree to the following:

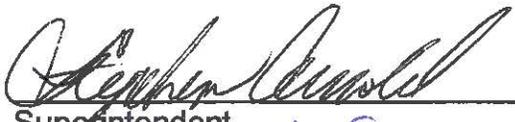
1. The Association will take to the membership the EPC Consortium Overview for a vote to be included in the EPC Consortium.
2. The EPC consortium health insurance rate for October 1, 2016 to September 30, 2017 will be set at a 1% increase and the dental rate will be set at -6% rate. The health and dental insurance plans provided through the EPC Consortium have slight variations from the Paulding County Consortium Plans, thus requiring this MOU.
3. The move to the EPC Consortium must be approved by all three of the Paulding County Schools by May 31, 2016. If one or more of the three schools do not have a MOU in place by May 31, 2016, the Paulding County Consortium will maintain its current plan beginning July 1, 2016, and continue to June 30, 2017, with a 3% increase for health and dental rates.
4. Insurance rates will be determined by the EPC Governing Board and the information will be shared to the membership when available each year. However, The Association and Board agree to maintain all current levels of benefits as stated above. If EPC benefit levels no longer exist or a change in coverage will occur, the Association will be notified prior to the change and the parties shall meet to negotiate the impact of the change prior to any changes made.
5. The wellness and the health assessment are voluntary and will not be required of any member. No information regarding health or wellness evaluations will be shared with any administrator in our district and no Bargaining Unit Member will be penalized for not utilizing these services.
6. As some specific exclusions exist on the overview sheet, those exclusions ("excluded from coverage") are understood and will not be a subject to #4 above should the benefits prove to be less. See overview sheet attached to this agreement.

7. This agreement in no way waives the rights of any Bargaining Unit Member or the Association.

This document is a TA to take to the membership. Once ratified and signed by both parties, this document shall serve as an addendum to the collective bargaining agreement.

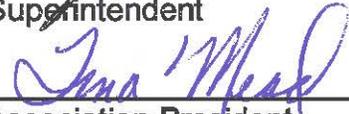
Superintendent TA SEA Date 5-31-16

Association TA TLM Date 5/31/16



Superintendent

5-31-16
Date



Association President

5/31/16
Date

Paulding County School Consortium
EPC Consortium Overview as of May 17, 2016

The EPC Consortium serves 77 districts and insures approximately 36,190 members. EPC has offered the schools of Paulding County a 1% increase in rates guaranteed for 15 months and a rate cap of 7% for the 2017 renewal. Paulding County School's renewal is July 1st and EPC originally requested a decision be made by 4/15/16. However, EPC has agreed to allow entrance into their consortium effective 10/1/16 but a decision must be made by 6/1/16. A change in consortiums would provide enhancements in some areas and changes in others. Below is an overview of the EPC programs based on information we have received as of May 17, 2016.

Highlights of the EPC Offer:

- Medical Benefits will remain the same.
- Anthem will continue as administrator.
- Continue with Anthem Network
- Deductibles and out-of-pocket paid in 2016 will transfer to EPC for the remainder of the calendar year. (No change)
- 4th Quarter Deductible Carry-Over for PPO Plans (not available on HDHP/H.S.A plan)
- Covered Employees can receive a gift card for completing a Health Assessment. Current value is \$50.
- Covered Employees can receive a gift card for completing a Wellness workshop. Current value is \$50.
- Members can buy a 90 day supply of medication at CVS Pharmacy for 2x the retail copay.
- HDHP/H.S.A Preventive Rx Listing – EPC indicates that the Caremark listing is same as current listing
- Continue with current Vision plans through VSP.
- Continue with current Life insurance plans.

Program changes with the EPC Offer:

- Dental administration will change from Anthem to Delta Dental. The benefits will remain the same; however there is a change in the Passive PPO Network going from Anthem to Delta Dental Network on 7/1/16.
 - Current Anthem Dental Plan and Delta Dental plans both pay non-network claims in the 90th percentile.
 - Payments will go to members when non-network dentist is utilized. Non-Networking dentists could require payment in advance of services but most will not do this.
 - Internal COB – when Husband & Wife are both employed by district/consortium, the plan will pay primary and secondary coverage.
- Prescription administration will change from Express Scripts to CVS Caremark on January 1, 2017.
- Specialty Medication will have to be filled through CVS's Specialty Pharmacy
- Rx Copays for Mail Order or through 90 Day CVS Retail program must be 2x Retail:
 - PPO 500 Plan: Current Mail Order is 15/80/240 and will change to 30/80/160
 - PPO 200 Plan: no change necessary
 - HDHP/H.S.A: Current Mail Order is 10/88/175 and will change to 20/70/140
- Clinical Equivalent Edits will be added to the Prescription plan.
 - Clinical Edits allows for more expensive brand medications or Over-the-Counter medications to be EXCLUDED from coverage when less expensive alternatives exist within a *Class of Medications*. Example: Nexium, Prilosec, Prevacid, Protonix and Zegerid are all considered Proton Pump Inhibitors (PPI). A Clinical Edit provision would allow the plan to exclude coverage for a more expensive PPI when a less expensive alternative is within the same class of medications. For instance, the EPC plan excludes coverage for:
 - Prevacid and Protonix but would cover Nexium, Dexilant, lansoprazole, omeprazole, and pantoprazole
- Differences in ExpressScript vs Caremark Formulary Listing could change copays on certain medications.
- Caremark Rx plan does exclude coverage for certain medications. Exception process is available but no guarantee on approvals.
- Medical dependent eligibility: EPC coverage cancels EOM Age 26 instead of current EOY Age 26. Grandfathering of current dependents is a possibility but new dependents will follow EOM age 26 stipulations.
- Dental dependent eligibility: EPC coverage cancels EOY Age 24 instead of current EOY Age 26. Grandfathering of current dependents is a possibility but new dependents will follow age 24 stipulations.

Your Anthem Health Benefits

Paulding County Schools – Wayne Trace – Blue AccessSM Blue 2.0 Grandf - Summary of Benefits – Effective 7/01/2014

APPENDIX W

This is considered contract language and an obligation of the Board.

Covered Benefits	Network	Non-Network
Deductible (Single/Family) <i>(Applies only to percent (%) copayments)</i>	\$200/\$400	\$400/800
Out-of-Pocket Maximum (Single/Family)	\$1,000/\$2,000	\$2,000/\$4,000
Physician Office Services Including Office Surgeries, allergy serum, & injections (1) • Allergy testing	\$15 Covered in Full	40% 40%
Preventive Care Medical History Mammography (1), Pelvic Exams, Pap testing, & PSA tests Immunizations (1) Annual diabetic eye exam Annual Vision & Hearing exams	\$15	40%
Outpatient Physical Medicine Therapies <i>(Combined Network & Non-network limits apply)</i> Physical/Occupational therapy: 20/20 visit limit Spinal manipulations: 12 visit limit Speech therapy: 20 visit limit	Copayments based on place of service	Copayments based on place of service
Inpatient Services Unlimited days except for: 60 days Network/Non-Network combined for physical medicine/rehab 180 days Network/Non-Network combined for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility	20%	40%
Other Outpatient Services Hospital/Alternative Care Facility	20%	40%
Inpatient and Outpatient Professional Charges	20%	40%
Home Care Services 30 visits non-network limit for Home Care, excludes IV therapy	20%	40%
Hospice Services	20%	40%
Emergency and Urgent Care: Emergency Care in Emergency Room <i>(covers all services, copayment waived if admitted, then inpatient copayment applies)</i> Urgent Care Facility	\$100 \$35	\$100 \$35
Ambulance Services	20%	20%
Maternity Services	20%	40%
Behavioral Health Services • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient/Professional	20% 20% No copayments/coinsurance No copayments/coinsurance	40% 40% 40% 40%
<small>These benefits have been tested & are compliant with Federal Mental Health Parity legislation. Call 1-800-788-4003 for authorized referral</small>		
Lifetime Maximum (Combined Network and Non-Network)	Unlimited	Unlimited

This is considered contract language and an obligation of the Board.

Covered Benefits	Network	Non-Network
Human Organ and Tissue Transplants Except Kidney and Cornea transplants (3)	Covered in Full	50%
Medical Supplies, Equipment, and Appliances	20%	40%
Prescription Drug Options ** Network Retail Pharmacies: (30 day supply) Includes diabetic test strip	\$10 Generic Formulary \$25 Brand Formulary \$40 Non-Formulary Brand & Generic	50%, min. \$40*
Anthem Rx Direct Mail Service: (90 day supply) Includes diabetic test strip	\$10 Generic Formulary \$25 Brand Formulary \$40 Non-Formulary Brand & Generic	Not Covered

Notes

- All deductibles and copayments apply to the Out-of-Pocket maximum (except prescription drug, human organ and tissue transplants, excluding kidney and cornea, and flat dollar copayments for Preventive care, Physician Office Services and Urgent Care).
- Deductible(s) apply only to covered services listed with a percentage (%) copayment excluding prescription drugs and allergy testing (Network). Deductible(s) do apply to allergy testing on Saver Plans.
- 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 to age 26.
- Certain diabetic and asthmatic supplies are covered in full at network pharmacies except diabetic test strips.
- (1) These covered services are covered in full if you have a flat dollar copayment and if rendered without an office visit.
- (2) Mental health/substance abuse must be authorized by the mental health administrator for services to be covered at the highest benefit level. Refer to Schedule of Benefits for limitations.
- (3) Kidney and Cornea are treated the same as any other illness and subject to the medical benefits and lifetime maximum.
- * RX non-network diabetic/asthmatic supplies are not covered except diabetic test strips.
- ** 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 help void any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-Existing Exclusion Period: NONE

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 preventative 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 and Blue Shield at the telephone number printed on the back of your member identification card, or contact our 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 Act at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Your Summary of Benefits



Paulding County School Consortium
 Lumence Health Savings Accounts Emb510HBA010 \$2500
 Summary of Benefits, Effective 07/01/2014

Deductible Family coverage requires the family deductible to be met before co-insurance applies. The single deductible does apply to family coverage.	Single: \$2,500 Family: \$5,000	Single: \$5,000 Family: \$10,000
Out-of-Pocket Limit	Single: \$5,000 Family: \$7,000	Single: \$7,000 Family: \$14,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) including Office Supplies and allergy exams: • Allergy Injections (PCP and SCP) • Allergy testing • MRIs, MRA, PETs, C-Scans, Nuclear Cardiology Imaging Studies, non-Maternity related Ultrasounds and Pharmaceuticals	0% 0% 0% 0%	30%
Preventive Care Services • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exams, Hearing examinations and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening	NOR	30%
Emergency and Urgent Care • Emergency Room Services @ Hospital (Qualify/other covered services) Urgent Care Center Services • MRIs, MRA, PETs, C-Scans, Nuclear Cardiology Imaging Studies, • Non-Maternity related Ultrasounds and Pharmaceuticals • Allergy Injections • Allergy testing	0% 0% 0% 0% 0%	0% 30%
Inpatient and Outpatient Professional Services include but are not limited to: • Medical Care visits, Intensive Medical Care, Operative Care, Consultation, Surgery and administration of general anesthesia and Newborn exams	0%	30%
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Your Summary of Benefits

Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> ● 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) ● 90 days for skilled nursing facility 	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> ● Surgery and administration of general anesthesia 	0%	30%
Other Outpatient Services including but not limited to: <ul style="list-style-type: none"> ● Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. ● Home Care Services 100 visits (excludes IV Therapy) (Network/Non-network combined) ● Durable Medical Equipment, Orthotics and Prosthetics ● Physical Medicine Therapy Day Rehabilitation programs ● Hospice Care ● Ambulance Services 	0%	30%
Accidental Dental Services \$3,000 limit per accident (Network and Non-network combined)	0%	30%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> ● Physician Home and Office Visits ● Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> ● Cardio Rehabilitation: 36 visits ● Pulmonary Rehabilitation: 20 visits ● Physical therapy: 20 visits ● Occupational therapy: 20 visits ● Speech therapy: 20 visits ● Manipulation therapy: 12 visits 	0%	30%
Behavioral Health Services: <ul style="list-style-type: none"> ● Inpatient Facility Services ● Physician Home and Office Visits (PCP/SPC) Other Outpatient Services @ Hospital/Alternative Care Facility	0%	30%
Human Organ and Tissue Transplants Acquisition and transplant procedures, harvest and storage.	0%	30%

Your Summary of Benefits

<p>Prescription Drugs</p> <ul style="list-style-type: none"> • Network Retail Pharmacies: (30-day supply) includes diabetic test strip • Home Delivery Service: (30-day supply) includes diabetic test strip <p>- Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service</p> <p>- Member may be responsible for additional cost when not selecting the available generic drug.</p> <p>Medicare Rx - Wrap</p>	<p>\$1000/175</p> <p>\$10000/175</p>	<p>60% min \$70*</p> <p>Not covered</p>
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- Notes:**
- All deductibles, copayments and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Vision Copay and Vision Telehealth)
 - Deductible(s) apply to covered services listed with copayments and a percentage (PI) coinsurance, including OI.
 - Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copay/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 calendar year with the child attains age 21.
 - OI means no-amounts 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
 - Hospital stay for laboratory coverage will not be billed in less than 48 hours for a vaginal delivery or 96 hours for a cesarean section.
 - Behavioral Health Services: Mental Health and Substance Abuse benefits provided in coordination with Federal/State/Health Policy.
 - Private Duty Home HC visits calendar year/104 hours
 - Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
 - **No Cost Share (NCS):** No deductible/copay/coinsurance up to the maximum allowable amount
- 1 We encourage you to review the Schedule of Benefits for details.
- 2 Rx non-network, diabetic test strips are not covered except diabetic test strips.
- *On the per-visit max \$100 30 day supply. This only applies to Option 5.

Prescription:
Members are encouraged to change their plan arrangement using non-network providers. Prescription will help the member bear if the member has a significant out-of-pocket expense.

Pre-existing Condition Waiver: NONE

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform law. As we receive additional guidance and clarification on the new health care reform law from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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.

Repeal the Summary of Benefits, I agree to the benefits for the period indicated as of the effective date indicated.

Authorized group election (if applicable)	Date
Underlying election (if applicable)	Date

**Your Anthem Dental Benefits
Paulding County Schools – Wayne Trace – Summary of Benefits – Effective 7/01/2004**

APPENDIX X

This is considered contract language and an obligation of the Board.

This is a partial listing of benefits and services.

BENEFITS	MEMBER'S RESPONSIBILITIES
Annual Deductible (Single/Family)	\$25/\$50 single/family
Annual Maximum	\$2,500
PREVENTIVE Diagnostic and Preventive Services (<i>no deductible</i>) <ul style="list-style-type: none"> • oral evaluations • X-rays (bitewing) • Cleanings • Space maintainers • Palliative treatment • Other selected diagnostics and preventive services 	Covered in Full
PRIMARY (<i>deductible applied</i>) <ul style="list-style-type: none"> • X-ray (full mouth) • General anesthesia (surgical procedures) • I.V. sedation (surgical procedures) • Amalgam and composite restorations • Pin retention procedures • Root canal therapy • Apexification • Therapeutic pulpotomy • Other selected endodontic services • Simple and surgical tooth extractions • Other selected oral surgery services • Gingivectomy • Osseous surgery • Other selected periodontal services 	20%
COMPLEX (<i>deductible applied</i>) <ul style="list-style-type: none"> • Crowns/inlays/onlays • Partial and full dentures • Other selected prosthodontic services Missing Tooth Rider <i>Services for the replacement of teeth (tooth) lost prior to the member's effective date of coverage under this plan.</i> <ul style="list-style-type: none"> • removable prosthodontics (partials or dentures) • fixed prosthodontics (bridges) for the replacement of teeth (or tooth) 	40% Not covered
ORTHODONTIC Orthodontic Services (<i>no deductible</i>) Dependent child to age 19 <ul style="list-style-type: none"> • non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth • examination • records • tooth guidance • repositioning (straightening) of the teeth • post orthodontic retention 	40% Child
Separate Orthodontic Lifetime Maximum	\$1,000
Provider Allowance	90 th percentile
Stand-alone Dental	Yes

Your Summary of Benefits



**Paulding County School Consortium
Lumenos Health Savings Accounts -Embedded
Effective 10/01/2016**

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does apply to family coverage.	Single: \$2,600 Family: \$5,000	Single: \$5,000 Family: \$10,000
Out-of-Pocket Limit	Single: \$3,500 Family: \$7,000	Single: \$7,000 Family: \$14,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> o Allergy injections (PCP and SCP) o Allergy testing o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals 	0% 0% 0% 0%	30%
Preventive Care Services <ul style="list-style-type: none"> o Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening 	No cost share	30%
Emergency and Urgent Care Emergency Room Services <ul style="list-style-type: none"> o facility/other covered services (copayment waived if admitted) Urgent Care Center Services <ul style="list-style-type: none"> o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, o Non-Maternity related Ultrasounds and Pharmaceuticals o Allergy injections o Allergy testing 	0% 0% 0% 0% 0%	0% 30%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> o Medical Care visits, Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 	0%	30%

Blue 8.6

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company, Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark 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

Covered Benefits	Network	Non-Network
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 90 days for skilled nursing facility 	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	0%	30%
Other Outpatient Services including but not limited to: <ul style="list-style-type: none"> Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. Home Care Services 100 visits (excludes IV Therapy) (Network/Non-network combined) Durable Medical Equipment, Orthotics and Prosthetics Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	0% 0%	30% 0%
Accidental Dental Services \$3,000 per accident (Network and Non-network combined)	0%	30%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Cardio Rehabilitation: 36 visits Pulmonary Rehabilitation: 20 visits Physical therapy: 20 visits Occupational therapy: 20 visits Speech therapy: 20 visits Manipulation therapy: 12 visits 	0% 0%	30% 30%
Behavioral Health Services: Mental Illness and Substance Abuse¹ <ul style="list-style-type: none"> Inpatient Facility Services Physician Home and Office Visits (PCP/SPC) Other Outpatient Services @ Hospital/Alternative Care Facility	0% 0% 0%	30% 30% 30%
Human Organ and Tissue Transplants Acquisition and transplant procedures, harvest and storage.	0%	30%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Prescription Drugs Network Tier structure equals 1/2/3 (and 4, if applicable) <ul style="list-style-type: none"> o Network Retail Pharmacies: (30-day supply) Includes diabetic test strip o Home Delivery Service: (90-day supply) Includes diabetic test strip <p>- Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service - Member may be responsible for additional cost when not selecting the available generic drug.</p> <p>Medicare Rx - Wrap</p>	<p>\$10/\$35/\$70</p> <p>\$20/\$70/\$140</p>	<p>50% min \$70²</p> <p>Not covered</p>

Notes:

- o All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
 - o Deductible(s) apply to covered services listed with a percentage (%) coinsurance and copayment including 0%.
 - o Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/ coinsurance applies.
 - o Network and Non-network Deductible, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
 - o **Dependent Age:** to the end of the calendar year which the child attains age 26
 - o 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.
 - o When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections
 - o 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.
 - o SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
 - o Benefit period = calendar year
 - o Hospital stay for Maternity coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
 - o Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
 - o Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
 - o No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
 - o Private Duty Nursing – limited to 82 visits/Calendar Year
 - o Wigs limited to 1 per benefit period.
 - o Vision limited services - additional vision services are covered when specifically coded as determination of refraction, routine ophthalmological examination including refraction for new and established patients, and a visual functional screening for visual acuity. No additional ophthalmological services are covered as part of the medical coverage.
- 1 We encourage you to review the Schedule of Benefits for limitations.
 2 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Precertification:

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

Pre-existing Exclusion Period: None

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Your Summary of Benefits

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.

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