



**HEALTH INSURANCE RATES**  
*Effective January 1, 2009*

**The Health Plan**

**PPO**

Single Coverage	\$20.77 per week/\$90.02 per month
Family Coverage	\$56.08 per week/\$243.02 per month

**Anthem Blue Cross**

**Dental**

Single Coverage	\$3.74 per week/\$16.22 per month
Family Coverage	\$10.74 per week/\$46.54 per month

**Met Life**

Accidental Death/Dismemberment Insurance	No Cost
Life Insurance	Driver's Choice of Contribution
Short Term Disability Insurance	Driver's Choice of Contribution

All new drivers are eligible for insurance on the first of the month following 90 days of employment. For instance, if a driver was hired on January 15, 2009, he/she would become eligible to receive insurance benefits on May 1, 2009.

Service Category	VALUE PPO 80%/\$20/\$1,000	
	PLANCODE	R35P/RC5P
	In-Network	Out-of-Network
Deductible (does not apply to out-of-pocket max)	\$1,000/\$3,000	\$3,000/\$9,000
Plan Payment	80% after deductible	60% after deductible
Out-of-Pocket Maximum (excludes deductibles)	\$6,000/\$12,000	\$12,000/\$24,000 or unlimited
Lifetime Benefit Maximum	\$2,000,000 IN/OON Combined	
<b>Inpatient Services</b>		
Hospital	80% after deductible	60% after deductible
Physician services	80% after deductible	60% after deductible
Rehabilitation	80% after deductible	60% after deductible
Days/Per Contract Year	100	IN/OON Combined
Skilled Nursing Facility	80% after deductible	60% after deductible
Days/Per Contract Year and/or Qualifying Dia	120	IN/OON Combined
<b>Physician Office Visits</b>		
Audiology (audiological exam)	\$20	60% after deductible
Visits/Per Contract Year	1	IN/OON Combined
Chiropractic Care	\$15	60% after deductible
Visits/Per Contract Year	\$20	IN/OON Combined
Primary Care (general practioner)	\$20	60% after deductible
Maternity Care	\$20 initial visit only	60% after deductible
OB/GYN Care	\$20	60% after deductible
Podiatry Care	\$20	60% after deductible
Specialist Care	\$20	60% after deductible
<b>Outpatient Services (Hospital, Home, Office, Other)</b>		
Allergy Injections	80% after deductible	60% after deductible
Ambulance Emergency Services	80% after deductible	80% after deductible
Non-Emergency	80% after deductible	Not covered
Biofeedback Therapy (urinary or fecal incontinence)	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible
Visits/Per Heart Attack or Heart Surgery	12 wks/36 vsts	IN/OON Combined
Durable Medical Equipment (limited to Plan's basic)	70% after deductible	50% after deductible
Emergency Room (copay waived if admitted, see In	\$75	\$75
Family Planning (contraceptive injection, IUD, diaph	80% after deductible	60% after deductible
Home Health (intermittent skilled care only, aide not	80% after deductible	60% after deductible
Home IV Therapy/Infusion Therapy	80% after deductible	60% after deductible
Hospice Care	80% after deductible	60% after deductible
Lifetime Maximum	180 days	IN/OON Combined
Infertility Services (limited to basic health care)	80% after deductible	60% after deductible
Oral Surgical Services (accidental or injury, repair to	80% after deductible	60% after deductible
Orthotics (limited to Plan's basic allowance)	70% after deductible	50% after deductible
Outpatient Diagnostic and Therapeutic Services (lab	80% after deductible	60% after deductible
radiology (to include MRI, MRA, CAT and PET scans), diagnostic tests and therapeutic treatments)		
Outpatient Surgery (to include office setting)	80% after deductible	60% after deductible
Preventive Care/Office Setting	\$20	60% after deductible
injections, immunizations, (pediatric/childhood, adolescent and adult); annual screening, physical exam (one per calendar year), well childcare and child health supervision services as prescribed by section 3923.55 of Ohio Revised Code.		
<b>*In-office screenings and exams, office visit copay will apply</b>		
Prosthetic (limited to Plan's basic allowance)	70% after deductible	50% after deductible
Pulmonary Rehabilitation	80% after deductible	60% after deductible
Visits/Per Contract Year	12 wks/36 vsts	IN/OON Combined
Radiation & Chemotherapy	80% after deductible	60% after deductible
Specialty Drugs	70% after deductible	50% after deductible
High Cost medications, used to treat very specific disease that that require extensive management for safety and effectiveness.		

These drugs require Preauthorization and may be dispensed through a pharmacy.		
Temporomandibular Joint Dysfunction (TMJ) (non-d	80% after deductible	60% after deductible
Therapy-Physical, Occupational & Speech (short-ter	80% after deductible	60% after deductible
Visits Each/Per Occurrence	20	IN/OON Combined
Urgent Care (copay waived if admitted, see Inpatient	\$35	60% after deductible

continued

VALUE PPO:80%/\$20/\$1,000		
Service Category Continued	PLANCODE	R35P/RC5P
	In-Network	Out-of-Network
	\$1,000/\$3,000	\$3,000/\$9,000
Deductible (does not apply to out-of-pocket max	80% after deductible	60% after deductible
Plan Payment	\$6,000/\$12,000	\$12,000/\$24,000 or unlimited
Out-of-Pocket Maximum (excludes deductibles)	\$2,000,000 IN/OON Combined	
Lifetime Benefit Maximum		
<b>Diabetic Coverage</b>	80% deductible waived	60% after deductible
Pharmacological Agents 31 day supply dispensed monthly, subject to formulary. *Insureds covered under a prescription drug rider will receive pharmacological agents through their prescription drug rider unless the benefits supplied through the rider are at a lesser level, all agent expenses will accumulate toward the annual prescription maximum, further coverage after the maximum is reached requires THP Preauthorization. Non formulary agents will be covered only if a specific medical indications exists whereby the listed formulary agents cannot be used, requires THP Preauthorization.	No cost to Insured	60% after deductible
Supplies (glucometers, syringes, lancets, glucose test strips, alcohol swabs, carp-u-jet, urine ketone testing strips & penlets)		
<b>Mental Health Services</b>	80% after deductible	60% after deductible
Inpatient Detoxification	80% after deductible	60% after deductible
Inpatient Substance Abuse Rehabilitation	30	IN/OON Combined
One Treatment Course/Lifetime Maximum End	80% after deductible	60% after deductible
Inpatient Mental Health Treatment	\$20	60% after deductible
Outpatient Substance Abuse Treatment	30	
Visits/Per Contract Year	\$20	60% after deductible
Outpatient Mental Health Treatment		
NOTE: THP will provide , outpatient and/or inpatient, a minimum alcohol abuse treatment benefit of \$550 per contract year		

## **Prescription Drug Rider**

**\$15 Generic/ \$30 Formulary Brand/ \$50 Non-Formulary Brand – Retail  
UNLIMITED ANNUAL MAXIMUM**

\$15 for a 31-day supply of a Generic drug obtained from a participating Plan retail pharmacy

\$30 for a 31-day supply of a Formulary Brand name drug obtained from a participating Plan retail pharmacy.

\$50 for a 31-day supply of a Non-Formulary Brand name drug obtained from a participating Plan retail pharmacy.

**Warning:** If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both Plans. Each plan may require you to follow its rules or use specific doctors, hospitals or pharmacies. It may be impossible to comply with both plans at the same time. Before you enroll, read all the rules very carefully including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

### **How to Use the Program**

As a Plan member, you may obtain your prescription drugs at any participating Plan Pharmacy. For the location of a participating pharmacy, please refer to the enclosed Plan Pharmacy List.

To fill your prescription at a retail pharmacy, just present your Plan Prescription ID card to the pharmacist with your prescription. You will be required to pay a copay at the time of service based on the following schedule:

\$15 copay for a qualified Generic prescription obtained from a participating Plan retail pharmacy.<sup>1</sup>

\$30 for a qualified Formulary Brand prescription obtained from a participating Plan retail pharmacy.<sup>2</sup>

\$50 for a Non-Formulary Brand prescription obtained from a participating Plan retail pharmacy.<sup>2</sup>

<sup>1</sup> A qualified generic prescription is an order for a drug that is available from multiple sources.

<sup>2</sup> A qualified brand prescription must be available only from a single source supplier of the particular drug.

Prescriptions must not be subject to any exclusions or limitations as outlined in the Exclusions and Limitations Section of this rider.

### **What is Covered**

The Plan covers "legend prescription drugs"<sup>3</sup> and medications only if such drugs are purchased at a participating Plan pharmacy and are prescribed by a participating Plan physician. Each

10. Prescriptions used to treat sexual dysfunction (oral, topical or injectable) or devices used for impotence.
11. Prescriptions drugs (oral, topical or injectable) for fertility, unless medically necessary.
12. Contraceptive devices. Oral contraceptives are covered.
13. Any injectable drugs except insulin, glucagon and epinephrine emergency kits (EpiPen).
14. Appliances and therapeutic devices which require a prescription are not covered. These include, but are not limited to, garments, splints, bandages or braces regardless of intended use.
15. There is no annual limit for prescription drugs per member per contract year.

Insurance Fraud Warning: Pursuant to Ohio Revised Code Section 3999.21, "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

### **The Plan Formulary**

The Plan formulary is a listing of prescription medications that are preferred for use. Preferred drugs will be a covered benefit when dispensed at participating pharmacies at a lower cost to you.

Non-formulary drugs are prescription medications that are not listed on the Plan formulary and therefore, are non-preferred for use. Non-preferred drugs will be covered when dispensed at participating pharmacies but at a higher cost to you.

### **72 Hour Cancellation Right**

Any person obligated for any part of a prepayment may cancel such agreement within 72 hours after he/she has signed an agreement or offered to enroll. Cancellation occurs when written notice of cancellation is given to the Plan. Notice of cancellation shall be considered given when the prospective subscriber mails a letter to the Plan.

### **Restriction on Choice of Providers**

The Plan will not pay for services or treatment ordered or rendered by health care providers who are not members of the Plan's Network except in emergency/urgent cases<sup>4</sup>. Pharmacies participating with the Plan are listed in the *Plan Pharmacy List*. Some of the providers may change from time to time.

<sup>4</sup> This exception does not apply to the Plan PPO or the Plan POS insureds.

prescription may be dispensed up to a 31-days supply from a retail pharmacy or a 90-day supply when obtained through the Medco Mail Order Service.

<sup>3</sup> "Legend prescription drugs" are those drugs which by Federal Law can be dispensed only pursuant to a prescription and which are required to bear the legend "Caution: Federal Law prohibits dispensing without a prescription."

### **Out-of-Area Emergencies**

In situations of emergency need for a prescription outside the Plan Service Area, please contact the Plan Prescription Benefit Manager (PBM) for the location of a participating pharmacy in that area at (800) 988-2262. Present your Plan Prescription ID card with the emergency prescription and pay your copay. If no pharmacy in the area participates with our PBM, purchase the emergency prescription and send your receipt to the Plan. You will be reimbursed in full, less your applicable copay, for the prescription provided the prescription meets the guidelines specified in this document.

Please refer to the Plan Pharmacy List for participating pharmacies.

Questions? Please call the Plan at (800) 426-9013 or (330) 837-6880, Monday through Friday from 8 a.m. to 5 p.m., or by e-mail at: [info@hometownhealthnet.com](mailto:info@hometownhealthnet.com).

### **Exclusions and Limitations**

The following will not be covered or paid for by the Plan.

1. The charge for any prescription refill other than the number set by the prescriber. No refills dispensed more than one year from the date of the original prescription.
2. The charge for any prescription oral, topical or injectable that is prescribed for cosmetic purposes.
3. The charge for any medications not FDA approved for use in the general population. Use of a FDA approved drug in the treatment of a non-FDA-approved indication.
4. The charge for a drug not prescribed by a Plan participating provider except in true emergency/urgent situations.
5. The charge for any medication covered by any Workers' Compensation or occupational disease laws, any other group policy or government program that is not the Plan's program.
6. Vitamins, except for prenatal are not covered. Prenatal vitamins are covered when related to a pregnancy only.
7. Dental related prescriptions such as, but not limited to, oral fluorides, dental mouthwashes or devices used in dental therapy.
8. Prescriptions related to smoking cessation, such as but not limited to nicotine patches, nicotine gum and Zyban.
9. Prescription for drugs or devices used to promote weight loss.

# Your Anthem Benefits



*BMC International, Inc*  
*Anthem Dental Traditional (group size 51+)*  
*Summary of Benefits, Effective 01/01/2007*

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Dental Certificate.

BENEFITS	MEMBER'S RESPONSIBILITY
Annual Deductible (Single/Family)	\$50/\$100 single/family
Annual Maximum	\$1,000
<b>PREVENTIVE</b>	Covered in full
Diagnostic and Preventive Services ( <i>no deductible</i> ) <ul style="list-style-type: none"> <li>oral evaluations</li> <li>X-rays (bitewing)</li> <li>cleanings</li> <li>space maintainers</li> <li>palliative treatment</li> <li>other selected diagnostic and preventive services</li> </ul>	
<b>PRIMARY (deductible applied)</b>	20%
<ul style="list-style-type: none"> <li>X-ray (full mouth)</li> <li>general anesthesia (surgical procedures)</li> <li>I.V. sedation (surgical procedures)</li> <li>amalgam and composite restorations</li> <li>pin retention procedures</li> <li>root canal therapy</li> <li>apexification</li> <li>therapeutic pulpotomy</li> <li>other selected endodontic services</li> <li>simple and surgical tooth extractions</li> <li>other selected oral surgery services</li> <li>gingivectomy</li> <li>osseous surgery</li> <li>other selected periodontal services</li> </ul>	
<b>COMPLEX (deductible applied)</b>	50%
<ul style="list-style-type: none"> <li>crowns/inlays/onlays</li> <li>partial and full dentures</li> <li>other selected prosthodontic services</li> </ul>	
<b>ORTHODONTIC</b>	40%
Orthodontic Services ( <i>no deductible</i> ) Dependent child to age 19 <ul style="list-style-type: none"> <li>non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth</li> <li>examination</li> <li>records</li> <li>tooth guidance</li> <li>repositioning (straightening) of the teeth</li> <li>post orthodontic retention</li> </ul>	
Separate Orthodontic Lifetime Maximum	\$750

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

Authorized group signature	Date
Underwriting signature	Date