GROUP & PENSION ADMINISTRATORS, INC.
PARK CENTRAL 8 • 12770 MERIT DRIVE 2ND FLOOR • DALLAS, TX 75251 • (972) 238-7900

Proposal Request Form

From: Veronica Hunt
Date: April 20, 2016
Account Manager: Mike Jones

Name of Group: City of Rockwall
City, State, Zip: Rockwall, TX 75087
Nature of Business: Municipality
Number of Lives: EE – 239; Dep - 144

Agent Location:
Morgan Young (Holmes Murphy)
Dallas, TX 75230

Lifetime Maximum: Unlimited
Annual Maximum: Unlimited

PPO Network: Cigna

Current Carrier: Great Midwest (Stop Loss Insurance Services) How Long: 4 months

Renewal Date: 1/1/2017 NEED QUOTE BY: ❖ ❖

Specific and/or Aggregate Excess Insurance Requested:

Benefits to be Covered: X Medical ____ Dental X Rx (include in Spec & Agg)

Specific Deductible Requested: 100,000*
*$90,000 Aggregating Specific

Desired Agent Commission: N/A %
Desired TPA Commission: N/A %
TOTAL Commission: N/A %

Type of Contract: 24/12 (Current) 24/12 (Requested)

Aggregate Requested: Yes Monthly Aggregate Requested: No

Type of Contract: 24/12 (Current) 24/12 (Requested)

CURRENT RATES

Specific Rates:	
Employee	58.25
Dependent	51.06

Aggregate Rates:	
Employee	4.21

Aggregate Factors:	
Employee	557.46
Dependent	1,070.91

Administration Fee:	19.95
UR: HealthWatch	3.00
PPO Fee: Cigna (UR Included)	16.54

Comments

PLEASE INCLUDE DISCOUNT FOR TRANSPLANT POLICY
AIG Transplant EE- $7.30;Dep- $9.50
Vision Administration - $1.00; Dental Administration - $2.50

See Benefit Code Definitions on page 2

GPA
GROUP & PENSION ADMINISTRATORS, INC.
PARK CENTRAL 8 • 12770 MERIT DRIVE 2ND FLOOR • DALLAS, TX 75251 • (972) 238-7900

DIVISION NAME	DIV #
ADMINISTRATION	001
ADMINISTRATION SERVICES	002
ANIMAL CONTROL	003
BLDG INSPECTIONS	004
CID	005
CODE ENFORCEMENT	006
COMMUNICATIONS	007
COMMUNITY SERVICES	008
ENGINEERING	009
FINANCE	010
FIRE MARSHAL	011
FIRE	012
INTERNAL OPS	013
MUNICIPAL COURT	014
PARKS	015
PATROL	016
PLANNING	017
POLICE ADMINISTRATION	018
RECORDS	019
RECREATION	020
SEWER	021
SPECIAL CRIMES	022
STREETS	023
UTILITY BILLING	024
WARRANTS	025
WATER OPERATIONS	026
REDC	027
CITY OF ROCKWALL (RETIREE)	998
CITY OF ROCKWALL (COBRA)	999

PLAN #'S:
PLAN # S=STANDARD PLAN
PLAN # P=PREMIUM PLAN
PLAN # DV=DENTAL & VISION ONLY
PLAN # DO=DENTAL ONLY
PLAN # VO=VISION ONLY

DEFINITIONS:
EE=EE MEDICAL
CH=CH MEDICAL
SP=SP MEDICAL
FA=SP+CH MEDICAL
VE=EE VISION
VS=EE+SP VISION
VC=EE+CH VISION
VF=EE+FA VISION
DE=EE DENTAL
DS=EE+SP DENTAL
DC=EE+CH DENTAL
DF=EE+FA DENTAL
OC=CIGNA PPO & UR FEE

GROUP & PENSION ADMINISTRATORS, INC.
FUND ACCOUNTING SUMMARY

H870374 City of Rockwall

(A) Period	(B) Coverage Revenue	(C) Fixed Costs	(D) Gross Claims	(E) Monthly Specific Stop Loss Claims	(F) Excluded Aggregate Charges	(G) Eligible Aggregate Claims	(H) Aggregate Attachment Pt.	(I) EE's	(J) Dep
Jan-16	282,659.71	36,638.71	246,021.00	**0.00**	(38,096.00)	207,925.00	284,788.71	240	141
Feb-16	276,635.33	36,263.33	240,372.00	**0.00**	(31,300.00)	209,072.00	286,930.53	240	143
Mar-16	750,730.33	36,370.33	714,360.00	(278,011.40)	(124,785.00)	311,563.60	287,487.99	241	143
Apr-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
May-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
Jun-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
Jul-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
Aug-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
Sep-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
Oct-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
Nov-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
Dec-16	0.00	0.00	0.00	**0.00**	**0.00**	0.00	0.00	0	0
Totals	1,310,025.37	109,272.37	1,200,753.00	(278,011.40)	(194,181.00)	728,560.60	859,207.23	Averages 240	142

Min. Att. Point: **3,359,371**

Coverage Revenue Detail

	Current Month	Year to Date
Funding: Gen Asset, Fixed Cost		
Employer Fixed Cost Funding	36,263.33	109,272.37
Employer Claims Cost Funding	240,372.00	1,200,753.00
Employee Funding	0.00	0.00
Other Funding	0.00	0.00
Total Coverage Revenue	276,635.33	1,310,025.37

Fixed Costs Detail

	Current Month	Year to Date
Life Premium	0.00	0.00
Stop-Loss Premium	22,354.44	66,836.28
Notification Fee	0.00	0.00
PPO Fees	3,986.14	11,925.34
Transplant Fee	3,117.80	9,319.80
Agent Compensation	0.00	0.00
Contract Administration	6,429.95	19,748.95
Nurse Navigator Fees	482.00	1,442.00
Yearly Transitional Reinsurance Fee	0.00	0.00
Total Fixed Costs	36,370.33	109,272.37

Excluded Aggregate Detail:	**Monthly**	**YTD**
Disease Mgmt Fee	3,229	3,909
Maternity Mgmt Fee	14	28
Nurse Navigator Fee	1,055	1,285
Rx Fee	1,337	2,682
Dental Charges	21,336	68,407
Vision Charges	7,814	27,870
Medical Review Fee	0	0
Agg Spec Claims	90,000	90,000
Total	**124,785**	**194,181**

Aggregate Claims Detail

YTD Total Claims Paid	1,200,753.00
YTD Incurred Claims Prior To Contract	**0.00**
YTD Benefits Not Covered Under Contract	(194,181.00)
YTD Current S/L Contract Specific Claims Paid	(278,011.40)
YTD Aggregate Stop-Loss Eligible Claims Paid	728,560.60

Specific Deductible:	100,000
Specific Contract:	24/12
Aggregate Contract:	24/12
Agg. Contract Includes:	MD,RX
Agg. Contract Excludes:	**SU,VS,DN**
Stop Loss Carrier:	Great MidWest Ins Co.
EE Agg. Factor:	$557.46
Dep Agg Factor:	$1,070.91

$90,000 Aggregating Specific. Claims that apply towards the aggregating specific are excluded from the aggregate contract.

YTD Exclued Charges: **90,000.00**

Specific Claim Detail:

Expected Prior Year Specific Claim Recovery	228,347.32
Prior Year Specific Claim Recovery	0.00
Expected Current Year Specific Claim Recovery	**278,011.40**
Current Year Specific Claim Recovery	**0.00**

This report is unaudited and may be subject to a minimum attachment point and other terms of the reinsurance contract.

GROUP & PENSION ADMINISTRATORS, INC.
FUND ACCOUNTING SUMMARY

H870374 City of Rockwall

(A) Period	(B) Coverage Revenue	(C) Fixed Costs	(D) Gross Claims	(E) Monthly Specific Stop Loss Claims	(F) Excluded Aggregate Charges	(G) Eligible Aggregate Claims	(H) Aggregate Attachment Pt.	(I) EE's	(J) Dep
Jan-15	271,684.82	37,149.82	234,535.00	**0.00**	(42,385.00)	192,150.00	274,232.30	235	135
Feb-15	185,880.58	36,645.58	149,235.00	**0.00**	(25,438.00)	123,797.00	274,824.64	236	135
Mar-15	274,015.85	37,038.85	236,977.00	**0.00**	(30,243.00)	206,734.00	277,194.00	240	135
Apr-15	281,458.64	37,649.64	243,809.00	**0.00**	(37,840.00)	205,969.00	281,155.94	245	136
May-15	282,792.61	37,252.61	245,540.00	**0.00**	(20,674.99)	224,865.01	278,378.68	242	135
Jun-15	239,767.61	37,251.61	202,516.00	**0.00**	(39,742.66)	162,773.34	278,378.68	242	135
Jul-15	293,885.97	38,204.97	255,681.00	**0.00**	(44,525.09)	211,155.91	286,749.48	246	141
Aug-15	204,383.42	36,348.42	168,035.00	**0.00**	(37,840.97)	130,194.03	272,231.82	235	133
Sep-15	226,593.49	36,919.49	189,674.00	**0.00**	(42,315.46)	147,358.54	277,417.46	237	137
Oct-15	280,476.75	36,896.75	243,580.00	**0.00**	(31,012.18)	212,567.82	277,825.36	236	138
Nov-15	378,028.77	62,524.77	315,504.00	(24,572.99)	(75,485.65)	215,445.36	280,194.72	240	138
Dec-15	466,774.16	37,602.16	429,172.00	(203,774.33)	(31,978.00)	193,419.67	281,971.74	243	138
Totals	3,385,742.67	471,484.67	2,914,258.00	(228,347.32)	(459,481.00)	2,226,429.68	3,340,554.82	Averages	
								240	136

Min. Att. Point: *Refer to Contract*

Coverage Revenue Detail	Current Month	Year to Date
Funding: Gen Asset, Fixed Cost		
Employer Fixed Cost Funding	37,602.16	471,484.67
Employer Claims Cost Funding	429,172.00	2,914,258.00
Employee Funding	0.00	0.00
Other Funding	0.00	0.00
Total Coverage Revenue	466,774.16	3,385,742.67

Fixed Costs Detail	Current Month	Year to Date
Life Premium	0.00	0.00
Stop-Loss Premium	23,380.05	277,034.41
Notification Fee	0.00	0.00
PPO Fees	3,951.18	46,796.02
Transplant Fee	3,353.58	39,734.84
Agent Compensation	0.00	0.00
Contract Administration	6,431.35	76,966.40
Nurse Navigator Fees	486.00	5,756.00
Yearly Transitional Reinsurance Fee	0.00	25,197.00
Total Fixed Costs	37,602.16	471,484.67

Excluded Aggregate Detail:	**Monthly**	**YTD**
Disease Mgmt Fee	1,422	12,561
Maternity Mgmt Fee	286	1,522
Nurse Navigator Fee	1,089	3,953
Rx Fee	1,331	16,023
Dental Charges	26,891	278,998
Vision Charges	959	55,638
Medical Review Fee	0	786
Agg Spec Claims	0	90,000
Total	**31,978**	**459,481**

Aggregate Claims Detail

YTD Total Claims Paid	2,914,258.00
YTD Incurred Claims Prior To Contract	**0.00**
YTD Benefits Not Covered Under Contract	(459,481.00)
YTD Current S/L Contract Specific Claims Paid	(228,347.32)
YTD Aggregate Stop-Loss Eligible Claims Paid	2,226,429.68

Specific Deductible:	100,000
Specific Contract:	24/12
Aggregate Contract:	24/12
Agg. Contract Includes:	MD,RX
Agg. Contract Excludes:	**SU,VS,DN**
Stop Loss Carrier:	Transamerica
EE Agg. Factor:	$592.34
Dep Agg Factor:	$1,000.24

$90,000 Aggregating Specific. Claims that apply towards the aggregating specific are excluded from the aggregate contract.

YTD Exclued Charges: **90,000.00**

Specific Claim Detail:

Expected Prior Year Specific Claim Recovery	0.00
Prior Year Specific Claim Recovery	0.00
Expected Current Year Specific Claim Recovery	**228,347.32**
Current Year Specific Claim Recovery	**0.00**

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GROUP & PENSION ADMINISTRATORS, INC.
FUND ACCOUNTING SUMMARY

H870374 City of Rockwall

(A) Period	(B) Coverage Revenue	(C) Fixed Costs	(D) Gross Claims	(E) Monthly Specific Stop Loss Claims	(F) Excluded Aggregate Charges	(G) Eligible Aggregate Claims	(H) Aggregate Attachment Pt.	(I) EE's	(J) Dep
Jan-14	374,438.82	42,771.82	331,667.00	**0.00**	(33,212.00)	298,455.00	265,027.28	238	140
Feb-14	306,928.24	42,315.24	264,613.00	**0.00**	(37,865.00)	226,748.00	262,800.16	236	140
Mar-14	273,192.55	41,872.55	231,320.00	**0.00**	(22,751.00)	208,569.00	259,459.48	233	137
Apr-14	325,286.50	41,872.50	283,414.00	**0.00**	(36,734.00)	246,680.00	258,345.92	232	138
May-14	190,130.17	43,103.17	147,027.00	**0.00**	(21,739.00)	125,288.00	267,254.40	240	141
Jun-14	260,846.17	43,103.17	217,743.00	**0.00**	(33,375.00)	184,368.00	267,254.40	240	141
Jul-14	388,829.31	42,780.31	346,049.00	**0.00**	(41,322.30)	304,726.70	263,913.72	237	141
Aug-14	193,519.84	43,204.84	150,315.00	**0.00**	(27,432.74)	122,882.26	269,481.52	242	140
Sep-14	220,376.66	43,321.66	177,055.00	**0.00**	(34,313.04)	142,741.96	269,481.52	242	141
Oct-14	456,468.28	43,417.28	413,051.00	**0.00**	(40,774.95)	372,276.05	270,595.08	243	141
Nov-14	376,941.17	80,052.17	296,889.00	**0.00**	(35,852.33)	261,036.67	269,481.52	242	134
Dec-14	351,832.57	41,952.57	309,880.00	**0.00**	(43,567.47)	266,312.53	263,913.72	237	134
Totals	3,718,790.28	549,767.28	3,169,023.00	**0.00**	(408,938.83)	2,760,084.17	3,187,008.72	Averages	
								239	139

Min. Att. Point: **2,339,818**

Coverage Revenue Detail

	Current Month	Year to Date
Funding: Gen Asset, Fixed Cost		
Employer Fixed Cost Funding	41,952.57	549,767.28
Employer Claims Cost Funding	309,880.00	3,169,023.00
Employee Funding	0.00	0.00
Other Funding	0.00	0.00
Total Coverage Revenue	351,832.57	3,718,790.28

Fixed Costs Detail

	Current Month	Year to Date
Life Premium	0.00	0.00
Stop-Loss Premium	28,420.16	347,836.50
Notification Fee	0.00	-15.00
PPO Fees	3,792.00	45,738.50
Transplant Fee	3,264.66	39,888.78
Agent Compensation	0.00	0.00
Contract Administration	6,001.75	73,056.50
Nurse Navigator Fees	474.00	5,714.00
Yearly Transitional Reinsurance Fee	0.00	37,548.00
Total Fixed Costs	41,952.57	549,767.28

Aggregate Claims Detail

YTD Total Claims Paid	3,169,023.00
YTD Incurred Claims Prior To Contract	**0.00**
YTD Benefits Not Covered Under Contract	(408,938.83)
YTD Current S/L Contract Specific Claims Paid	**0.00**
YTD Aggregate Stop-Loss Eligible Claims Paid	2,760,084.17

Specific Deductible:	100,000
Specific Contract:	84/12
Aggregate Contract:	84/12
Agg. Contract Includes:	MD,RX
Agg. Contract Excludes:	**SU,VS,DN**
Stop Loss Carrier:	ING
Composite Agg. Factor:	$1,113.56

$90,000 Aggregating Specific. Claims that apply towards the aggregating specific are excluded from the aggregate contract.

YTD Exclued Charges: **49,726.83**

Specific Claim Detail:

Expected Prior Year Specific Claim Recovery	0.00
Prior Year Specific Claim Recovery	216,545.32
Expected Current Year Specific Claim Recovery	**0.00**
Current Year Specific Claim Recovery	**0.00**

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GROUP & PENSION ADMINISTRATORS, INC.
FUND ACCOUNTING SUMMARY

H870374 City of Rockwall

(A) Period	(B) Coverage Revenue	(C) Fixed Costs	(D) Gross Claims	(E) Monthly Specific Stop Loss Claims	(F) Stop Loss RX Reimbursements	(G) Excluded Aggregate Charges	(H) Eligible Aggregate Claims	(I) Aggregate Attachment Pt.	(J) EE's	(K) Dep
Jan-13	181,285.33	40,451.33	140,834.00	**0.00**	**0.00**	(18,834.00)	122,000.00	226,118.88	208	118
Feb-13	217,580.20	39,353.20	178,227.00	**0.00**	**0.00**	(57,079.00)	121,148.00	221,770.44	204	118
Mar-13	216,157.18	39,125.18	177,032.00	(38.00)	**0.00**	(35,855.00)	141,139.00	220,683.33	203	117
Apr-13	261,421.18	39,105.18	222,316.00	(8,969.66)	**0.00**	(67,460.00)	145,886.34	220,683.33	203	117
May-13	181,367.09	39,242.09	142,125.00	(4,197.14)	**0.00**	(36,593.00)	101,334.86	223,944.66	206	115
Jun-13	202,385.42	38,598.42	163,787.00	(9,678.92)	**0.00**	(49,033.00)	105,075.08	219,596.22	202	113
Jul-13	218,014.59	39,329.59	178,685.00	(20,697.47)	**0.00**	(58,696.00)	99,291.53	223,944.66	206	115
Aug-13	201,227.07	39,197.07	162,030.00	(3,477.56)	**0.00**	(47,671.00)	110,881.44	219,596.22	202	118
Sep-13	161,552.46	38,199.46	123,353.00	(4,794.87)	**0.00**	(31,602.00)	86,956.13	217,422.00	200	112
Oct-13	310,567.68	38,256.68	272,311.00	(11,680.20)	**0.00**	(73,879.00)	186,751.80	219,596.22	202	110
Nov-13	239,130.24	39,042.24	200,088.00	(14,424.19)	**0.00**	(34,207.00)	151,456.81	222,857.55	205	113
Dec-13	493,639.84	39,353.84	454,286.00	(197,873.99)	**0.00**	(46,408.00)	210,004.01	223,944.66	206	115
Totals	2,884,328.28	469,254.28	2,415,074.00	(275,832.00)	**0.00**	(557,317.00)	1,581,925.00	2,660,158.17	Averages	
									204	115
							Min. Att. Point:	**2,395,126**		

Coverage Revenue Detail

	Current Month	Year to Date
Funding: Gen Asset, Fixed Cost		
Employer Fixed Cost Funding	39,353.84	469,254.28
Employer Claims Cost Funding	454,286.00	2,415,074.00
Employee Funding	0.00	0.00
Other Funding	0.00	0.00
Total Coverage Revenue	493,639.84	2,884,328.28

Fixed Costs Detail

	Current Month	Year to Date
Life Premium	0.00	0.00
Stop-Loss Premium	26,760.93	319,361.28
Notification Fee	111.00	1,251.00
PPO Fees	3,293.50	38,983.50
ELAP Fee	0.00	0.00
Transplant Fee	2,653.41	31,657.20
Agent Compensation	0.00	0.00
Contract Administration	6,049.00	72,273.30
Nurse Navigator Fees	486.00	5,728.00
Total Fixed Costs	39,353.84	469,254.28

Aggregate Claims Detail

YTD Total Claims Paid	2,415,074.00
YTD Incurred Claims Prior To Contract	**0.00**
YTD Benefits Not Covered Under Contract	(557,317.00)
Current S/L Contract RX Reimbursements	**0.00**
YTD Current S/L Contract Specific Claims Paid	(275,832.00)
YTD Aggregate Stop-Loss Eligible Claims Paid	1,581,925.00

Specific Deductible:	75,000
Specific Contract:	72/12
Aggregate Contract:	72/12
Agg. Contract Includes:	MD,RX
Agg. Contract Excludes:	**SU,VS,DN Core Plan**
Stop Loss Carrier:	ING
Composite Agg. Factor:	$1,087.11

Specific Claim Detail:

Expected Prior Year Specific Claim Recovery	0.00
Prior Year Specific Claim Recovery	49,323.79
Expected Current Year Specific Claim Recovery	**199,210.23**
Current Year Specific Claim Recovery	**76,621.77**

This report is unaudited and may be subject to a minimum attachment point and other terms of the reinsurance contract.

£18-Apr-2016 CLAIM ANALYSIS FOR GROUP & PENSION ADMINISTRATORS, INC., FOR CASE: H870374 CITY OF ROCKWALL

						M O N T H	I N C U R R E D							
	MAR 16	FEB 16	JAN 16	DEC 15	NOV 15	OCT 15	SEP 15	AUG 15	JUL 15	JUN 15	MAY 15	APR 15	MAR 15	PRIOR	TOTAL
MAR 16	72799	599846	79769	6506	2912	2978	424	541		594		180	34	619	767203
FEB 16		61115	111973	47817	8619	4459	2883	1941	48	811	908		56	-259	240372
M JAN 16			67825	134873	35640	2384	2149	1506	1517	159	-53			20	246021
O DEC 15															0
N NOV 15															0
T OCT 15															0
H SEP 15															0
AUG 15															0
P JUL 15															0
A JUN 15															0
I MAY 15															0
D APR 15															0
MAR 15															0
PRIOR															0
TOTAL	72799	660961	259567	189197	47171	9821	5457	3988	1565	1564	855	180	91	380	1253596
PREMIUM		24347	26098												50445
L/R %		2714.77%	994.57%												2485.06%
CASES	1	1	1												
INDIV'S	1446	1441	1435												

Case Range: H870374-H870374
Division Range:
Date Range: 01/01/2016-03/31/2016
Claim Type:
Check Format:
Premium Carrier:
Premium Type: Actual
Active Only: N
% Prem/Claims: 1/1
Prt Claim Type: Y

Case Field 1: 0
Case Field 2: 0
Draft field: 32
-5
Initial Date: Y
Chg Types: -TRFE

MEMBER CLAIMS :	$439,088	35.03%
DEPENDENT CLAIMS:	$814,508	64.97%
BENEFIT TC3 :	$7,526	0.60%
BENEFIT CSMG :	$2,490	0.20%
BENEFIT DMFG :	$3,908	0.31%
BENEFIT MMF :	$27	0.00%
BENEFIT NNF :	$1,285	0.10%
BENEFIT RXC :	$173,082	13.81%
BENEFIT ADRX :	$4,029	0.32%
BENEFIT DOEX :	$8,515	0.68%
BENEFIT DPX :	$14,826	1.18%
BENEFIT ROV :	$13,360	1.07%
BENEFIT DBW :	$6,081	0.49%
BENEFIT DFL :	$2,487	0.20%
BENEFIT 1DXL :	$249	0.02%
BENEFIT DFMP :	$2,464	0.20%
BENEFIT VFRM :	$7,327	0.58%
BENEFIT VSIN :	$4,654	0.37%
BENEFIT DENB :	$17,447	1.39%
BENEFIT DENP :	$1,860	0.15%
BENEFIT OPSH :	$46,393	3.70%
BENEFIT RMAM :	$411	0.03%
BENEFIT WCIM :	$5,881	0.47%
BENEFIT OHPH :	$2,771	0.22%
BENEFIT HV :	$1,713	0.14%
BENEFIT DXL :	$934	0.07%
BENEFIT SURG :	$4,466	0.36%
BENEFIT ASST :	$983	0.08%
BENEFIT ANES :	$8,977	0.72%
BENEFIT PT :	$13,944	1.11%
BENEFIT HMHC :	$66,087	5.27%
BENEFIT OV :	$15,230	1.21%
BENEFIT IDXL :	$3,415	0.27%
BENEFIT OCC :	$160	0.01%
BENEFIT OVXL :	$5,638	0.45%
BENEFIT OPA :	$14,044	1.12%
BENEFIT OPXL :	$2,312	0.18%

CLAIM TYPE 29:	$87,550	6.98%
CLAIM TYPE HW:	$7,710	0.62%
CLAIM TYPE PC:	$177,110	14.13%
CLAIM TYPE 32:	$68,659	5.48%
CLAIM TYPE 15:	$19,402	1.55%
CLAIM TYPE 13:	$27,789	2.22%
CLAIM TYPE 00:	$28,817	2.30%
CLAIM TYPE 26:	$60,023	4.79%
CLAIM TYPE 11:	$17,662	1.41%
CLAIM TYPE 14:	$12,173	0.97%
CLAIM TYPE 16:	$78,467	6.26%
CLAIM TYPE 06:	$14,149	1.13%
CLAIM TYPE 17:	$50,807	4.05%
CLAIM TYPE 12:	$3,118	0.25%
CLAIM TYPE 30:	$479,513	38.25%
CLAIM TYPE 25:	$1,642	0.13%
CLAIM TYPE 23:	$1,255	0.10%
CLAIM TYPE 09:	$1,818	0.15%
CLAIM TYPE 04:	$16,219	1.29%
CLAIM TYPE 07:	$4,557	0.36%
CLAIM TYPE 03:	$10,765	0.86%
CLAIM TYPE 10:	$0	0.00%
CLAIM TYPE 05:	$667	0.05%
CLAIM TYPE 27:	$76,378	6.09%
CLAIM TYPE 01:	$638	0.05%
CLAIM TYPE 24:	$2,937	0.23%
CLAIM TYPE 31:	$2,311	0.18%
CLAIM TYPE 28:	$650	0.05%
CLAIM TYPE 22:	$808	0.06%

BENEFIT OPS	:	$11,160	0.89%
BENEFIT RDXL	:	$3,228	0.26%
BENEFIT VEXM	:	$3,980	0.32%
BENEFIT VBIF	:	$3,485	0.28%
BENEFIT VTNT	:	$1,995	0.16%
BENEFIT ERPH	:	$13,999	1.12%
BENEFIT EXL	:	$2,928	0.23%
BENEFIT OVIN	:	$690	0.06%
BENEFIT RIMM	:	$566	0.05%
BENEFIT DSEL	:	$898	0.07%
BENEFIT ER	:	$42,189	3.37%
BENEFIT VCON	:	$4,718	0.38%
BENEFIT HMIS	:	$415,555	33.15%
BENEFIT DORT	:	$2,896	0.23%
BENEFIT INPX	:	$1,715	0.14%
BENEFIT RXH	:	$52,844	4.22%
BENEFIT RCOL	:	$10,938	0.87%
BENEFIT RPI	:	$135	0.01%
BENEFIT HER	:	$35,098	2.80%
BENEFIT CHIR	:	$775	0.06%
BENEFIT OVSU	:	$1,239	0.10%
BENEFIT RDPR	:	$215	0.02%
BENEFIT RMPI	:	$464	0.04%
BENEFIT OHXL	:	$7,059	0.56%
BENEFIT OVDT	:	$1,709	0.14%
BENEFIT SLSV	:	$13,442	1.07%
BENEFIT OPH	:	$17,076	1.36%
BENEFIT SLPR	:	$1,024	0.08%
BENEFIT ACUP	:	$952	0.08%
BENEFIT 1VEX	:	$1,057	0.08%
BENEFIT OVSP	:	$43	0.00%
BENEFIT GYN	:	$1,635	0.13%
BENEFIT RPPI	:	$258	0.02%
BENEFIT DENM	:	$10,794	0.86%
BENEFIT SADT	:	$0	0.00%
BENEFIT MNOP	:	$566	0.05%
BENEFIT AINJ	:	$108	0.01%
BENEFIT HICU	:	$49,607	3.96%
BENEFIT HRB	:	$0	0.00%
BENEFIT HIT	:	$21,113	1.68%
BENEFIT IPDT	:	$72	0.01%
BENEFIT IFT	:	$1,090	0.09%
BENEFIT HMSP	:	$3,877	0.31%
BENEFIT MDSP	:	$324	0.03%
BENEFIT COLS	:	$806	0.06%
BENEFIT SDOS	:	$98	0.01%
BENEFIT SLT	:	$11,694	0.93%
BENEFIT NSTR	:	$1,632	0.13%
BENEFIT DME	:	$6,039	0.48%
BENEFIT 1VRF	:	$151	0.01%
BENEFIT PE	:	$2,127	0.17%
BENEFIT OPDT	:	$105	0.01%
BENEFIT WCEX	:	$3,242	0.26%
BENEFIT WLCH	:	$646	0.05%
BENEFIT HEXM	:	$119	0.01%
BENEFIT ORT	:	$834	0.07%

BENEFIT ERDR	:	$7,466	0.60%
BENEFIT ERXL	:	$1,128	0.09%
BENEFIT SEOP	:	$798	0.06%
BENEFIT RPSA	:	$176	0.01%
BENEFIT MTID	:	$297	0.02%
BENEFIT RPAP	:	$142	0.01%
BENEFIT NBMS	:	$483	0.04%
BENEFIT	:	$7,117	0.57%
BENEFIT $ADJ	:	$6	0.00%

STANDARD PLAN
SCHEDULE OF BENEFITS

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

Benefit levels for services rendered in the geographic zip code area serviced by the Preferred Provider Organization (PPO):

The "PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network). The "PPO Benefit" also applies to the following situations:

1. If a PPO Provider refers a Covered Person to a Facility which is not in the PPO Network because no appropriate PPO Facility is available within the PPO service area;
2. If a PPO Provider refers a Covered Person to a Physician who is not in the PPO Network because there is no appropriate specialist available among PPO Providers;
3. If a Medical Emergency or initial treatment of an Accidental Injury requires immediate care, and services are rendered by Non-PPO Providers;
4. If a Covered Person receives Medically Necessary services from a Non-PPO Provider because the Covered Person is living or traveling outside of the geographic zip code area serviced by the PPO (Out-of-Area); or
5. If a Covered Person seeks treatment in a PPO Hospital or Free-standing Facility, and required services are rendered by a Non-PPO radiologist, anesthesiologist, pathologist, assistant surgeon or on-call Physician/specialist.

	PPO Benefit	Non-PPO Benefit
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited	
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited	
Calendar Year Deductible Per Covered Person Family Limit*	 $2,750 $5,500	
Common Accident Deductible Applies when two (2) or more Covered Persons in the same Family are Injured in the same Accident. Only one (1) Calendar Year Deductible will apply to charges related to the Accident.	$2,500	
Benefit Percentage (Unless otherwise noted)	90%	60%
Annual Out-of-Pocket Maximum (Includes Deductible, Medical Copays, Prescription Drug Copays and Vision Expenses for Covered Persons under age 19) Per Covered Person Family Limit*	 $5,750 $11,000	 No Maximum No Maximum

NOTE: The Calendar Year Deductible and Annual Out-of-Pocket Maximum are determined by combining both PPO and Non-PPO Covered Charges. Upon reaching the Annual Out-of-Pocket Maximum, PPO Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year. The Lifetime and Calendar Year Maximums are also determined by combining PPO and Non-PPO Covered Charges. The Coinsurance reflected in this Schedule of Benefits is the Plan's Benefit Percentage. The Covered Person is responsible for the difference between the Plan's Benefit Percentage and 100%.

*Applies collectively to all Covered Persons in the same Family.

STANDARD PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit	Non-PPO Benefit
Inpatient Hospital Services (All related charges) Utilization Review (UR) Notification required or penalty applies.	90% after Deductible	60% after Deductible
Inpatient Hospital Copay per Confinement (applies to each Hospital confinement)	None	$500
Non-compliance Penalty Per Admission (For failure to notify UR Company of Hospital admission.) See Utilization Review Program section.	$1,000	$1,000
Hospital Emergency Room (All related charges) UR Notification required if admitted Inpatient or penalty applies.		
Treatment of Medical Emergency/Accidental Injury	90% after Deductible	90% after Deductible
Treatment of Illness not a Medical Emergency (ER Copay waived if admitted Inpatient)	$150 Copay; then 90% after Deductible	$150 Copay; then 60% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	90% after Deductible	60% after Deductible
Retail Limited Service Clinics (All related lab charges)	100% after $20 Copay	
Helping Hands Clinic (All related lab charges)	100% after $20 Copay	Not Covered
Airrosti Services (Effective May 1, 2012) Office Visit	100% after $20 Copay	
Ambulance Service	90% after Deductible	90% after Deductible
Outpatient Surgery/Ambulatory Surgical Center (All related charges)	90% after Deductible	60% after Deductible
Colonoscopy (diagnostic)	100% after $100 Copay	60% after Deductible
Calendar Year Maximum Benefit	1	
Lab and X-ray Benefit (Procedures performed in Outpatient department of Hospital, free-standing center or independent Facility)	90% after Deductible	60% after Deductible
Physician Office Services Office Visit (Includes examination, treatment, Surgery, lab, x-ray, tests and supplies provided by and billed by Physician at the time of the Office Visit)	90% after Deductible	60% after Deductible

STANDARD PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit	Non-PPO Benefit
Allergy Testing, Serum and Injections	90% after Deductible	60% after Deductible
Injectable Hormones (administered in Physician's office)	100% after $100 Copay	60% after Deductible
Voluntary Second Surgical Opinion	90% after Deductible	60% after Deductible
All Other Physician Services	90% after Deductible	60% after Deductible
Maternity (Inpatient Hospital charges and Physician services, including prenatal care, delivery and postnatal care) Contact the Utilization Review Company for Coordination of Care.	90% after Deductible	60% after Deductible
Routine Newborn Care (Inpatient Hospital nursery charges and pediatric care to date of mother's discharge) Payable under covered mother's Claim. Baby must be added as a Dependent within **thirty (30) days** of birth to be eligible for this benefit.	90% Deductible waived	60% Deductible waived
Chemotherapy/Radiation Therapy/ Infusion Therapy Contact the Utilization Review Company for Coordination of Care.	90% after Deductible	60% after Deductible
Dialysis UR Notification required.	90% after Deductible	60% after Deductible
Outpatient Cardiac Rehabilitation	90% after Deductible	60% after Deductible
Outpatient Physical Therapy	90% after Deductible	60% after Deductible
Calendar Year Maximum Number of Visits	60	
Outpatient Occupational Therapy	90% after Deductible	60% after Deductible
Calendar Year Maximum Number of Visits	60	
Outpatient Speech Therapy	90% after Deductible	60% after Deductible
Calendar Year Maximum Number of Visits	60	
Durable Medical Equipment (DME)/ Medical Supplies/Prosthetics/Orthotic Devices (not to include Orthotic Insoles)	90% after Deductible	60% after Deductible
Diabetic Self-Management Training	90% after Deductible	60% after Deductible

STANDARD PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit		Non-PPO Benefit
Temporomandibular Joint (TMJ) Disorders	90% after Deductible		60% after Deductible
Calendar Year Maximum Benefit		$1,000	
Lifetime Maximum Benefit		$5,000	
Sleep Disorders Contact the Utilization Review Company for Coordination of Care. (Covered Services include, office visits, sleep studies/ diagnostic testing, Surgery, devices and equipment)	90% after Deductible		60%after Deductible
Lifetime Maximum Number of Office Visits		25	
Lifetime Maximum Number of Sleep Studies (Diagnostic Testing)		5	
Lifetime Maximum for CPAP		1	
Lifetime Maximum Number of Surgeries		1	
Rehabilitation Facility UR Notification required*	90% after Deductible		60% after Deductible
Skilled Nursing Facility UR Notification required*	90% after Deductible		60% after Deductible
Maximum Number of Covered Days per Calendar Year		60	
* Notification to the Utilization Review (UR) Company is required within forty-eight (48) hours following admission or penalty applies.			
Home Health Care Contact the Utilization Review Company for Coordination of Care.	90% after Deductible		60% after Deductible
Maximum Number of Covered Days per Calendar Year (Applies to part-time or intermittent nursing care visits and therapy services)		60	
Home Infusion Therapy Contact the Utilization Review Company for Coordination of Care.	90% after Deductible		60% after Deductible
Hospice Contact the Utilization Review Company for Coordination of Care.	90% after Deductible		60% after Deductible
Private Duty Nursing Contact the Utilization Review Company for Coordination of Care.	90% after Deductible		60% after Deductible
Maximum Number of Covered Days per Calendar Year		60	

STANDARD PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit	Non-PPO Benefit
Acupuncture		
City of Rockwall Direct Contracted Providers	90% Deductible waived	Not Covered
Calendar Year Maximum Number of Visits	30	
Chiropractic Services (Includes x-rays)	90% after Deductible	60% after Deductible
Calendar Year Maximum Number of Visits	30	
Mental Disorders, Chemical Dependency, Drug and Substance Abuse		
Inpatient UR Notification required or penalty applies.	90% after Deductible	60% after $500 Copay Deductible applies
Residential Treatment Center/Residential Treatment Center for Children and Adolescents/Crisis Stabilization Unit UR Notification required or penalty applies.	90% after Deductible	60% after Deductible
Outpatient Day Treatment Facility	90% after Deductible	60% after Deductible
Psychological Testing	90% after Deductible	60% after Deductible
Outpatient Therapy	90% after Deductible	60% after Deductible
Office Visit	90% after Deductible	60% after Deductible

Organ and Tissue Transplants, Donor Expenses
Contact Utilization Review Company upon transplant evaluation for Coordination of Care. (Refer to Organ Transplant Policy section of this Plan Document – Primary payor). See Major Medical Expense Benefits.

STANDARD PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit	Non-PPO Benefit
Preventive and Wellness Care Benefits This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam/or as specified below.	100%; Deductible waived	Not Covered

Examples of Covered Wellness Procedures include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. Annual Pap smear and other routine lab
4. Bone Density test (routine, age 60 and older or family history of osteoporosis)
5. Annual PSA test (routine)
6. Well Baby Care Exam/Well Child Care Exam
7. Routine Immunizations
8. Flu vaccine/pneumonia vaccine
9. Routine lab, x-ray, diagnostic testing and other medical screenings
10. Annual Routine Vision Exam (under age 19)
11. Routing Hearing Exam (newborns)
12. Tobacco Use Screening/Cessation Intervention (limited to two Office Visits per Lifetime)
13. All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures
14. All other covered Women's ACA preventive services for covered Employees and covered Dependents (includes prenatal care and breast feeding support)

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

Mammogram		
Age 40 and older (Routine, one per Calendar Year)	100% Deductible waived	Not Covered
Baseline Mammogram (One between ages 35 and 40)	100% Deductible waived	Not Covered
Prior to age 35 (with family history of breast cancer)	90% after Deductible	Not Covered
Routine Colonoscopy Age 50 and older	100% Deductible waived	Not Covered
Age 45-49 (or family history of colon cancer)	90% Deductible waived	Not Covered
Hearing Care Benefit (Including Exam and Hearing Aids)	100% Deductible waived	100% Deductible waived
Lifetime Maximum Hearing Care Benefit Per Covered Person	$2,000	
All Other Covered Medical Expenses, not listed in the Schedule of Benefits are payable at the applicable Benefit Percentage after satisfying the Calendar Year Deductible subject to the Plan Maximums and Limitations.	90% after Deductible	60% after Deductible

STANDARD PLAN VISION CARE PLAN

	Benefit
Annual Routine Vision Exam	100%; Deductible waived
Calendar Year Maximum Benefit for Exam	$50
Eyeglasses/Contact Lenses (Including fitting of contact lenses)	100%; Deductible waived
Calendar Year Maximum Vision Benefit Per Covered Person for Vision Hardware	$250
NOTE: Vision Expenses for Covered Persons under age 19 are not subject to the Calendar Year Maximum Vision Benefit. Vision Expenses for Covered Persons under age 19 also apply to the Annual Out-of-Pocket Maximum.	
Vision Correction Surgery (Lasik and similar procedures)	100%; Deductible waived
Lifetime Maximum Benefit	$500

LIST OF COVERED VISION CARE SERVICES

The following is a complete list of vision care services for which benefits are payable under the Plan. No benefits are payable for a service which is not listed.

1. Vision examination (including refraction)
2. Single vision lenses
3. Bifocal lenses
4. Trifocal lenses
5. Lenticular lenses
6. Frame
7. Tint allowance
8. Contact lenses
9. Fitting of contact lenses
10. Prescription sunglasses

LIMITATIONS

Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. Vision examination more than once in a Calendar Year period;
2. Charges for Vision examinations in excess of the Calendar Year Maximum Benefit;
3. Charges for eyeglasses and contact lenses in excess of the Calendar Year Maximum Benefit;
4. Charges for lasik surgery in excess of the Lifetime Maximum Benefit;
5. Orthoptics or vision training and any associated testing; and
6. Any eye examination, or any corrective eyewear, required by the Employer as a condition of employment.

PREMIUM PLAN
SCHEDULE OF BENEFITS

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

Benefit levels for services rendered in the geographic zip code area serviced by the Preferred Provider Organization (PPO):

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1. If a PPO Provider refers a Covered Person to a Facility which is not in the PPO Network because no appropriate PPO Facility is available within the PPO service area;
2. If a PPO Provider refers a Covered Person to a Physician who is not in the PPO Network because there is no appropriate specialist available among PPO Providers;
3. If a Medical Emergency or initial treatment of an Accidental Injury requires immediate care, and services are rendered by Non-PPO Providers;
4. If a Covered Person receives Medically Necessary services from a Non-PPO Provider because the Covered Person is living or traveling outside of the geographic zip code area serviced by the PPO (Out-of-Area); or
5. If a Covered Person seeks treatment in a PPO Hospital or Free-standing Facility, and required services are rendered by a Non-PPO radiologist, anesthesiologist, pathologist, assistant surgeon or on-call Physician/specialist.

	PPO Benefit	Non-PPO Benefit
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited	
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited	
Calendar Year Deductible Per Covered Person Family Limit*	 $1,750 $3,500	
Common Accident Deductible Applies when two (2) or more Covered Persons in the same Family are Injured in the same Accident. Only one (1) Calendar Year Deductible will apply to charges related to the Accident.	$1,500	
Benefit Percentage (Unless otherwise noted)	90%	60%
Annual Out-of-Pocket Maximum (Includes Deductible, Medical Copays, Prescription Drug Copays and Vision Expenses for Covered Persons under age 19) Per Covered Person Family Limit*	 $3,750 $7,000	 No Maximum No Maximum

NOTE: The Calendar Year Deductible and Annual Out-of-Pocket Maximum are determined by combining both PPO and Non-PPO Covered Charges. Upon reaching the Annual Out-of-Pocket Maximum, PPO Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year. The Lifetime and Calendar Year Maximums are also determined by combining PPO and Non-PPO Covered Charges. The Coinsurance reflected in this Schedule of Benefits is the Plan's Benefit Percentage. The Covered Person is responsible for the difference between the Plan's Benefit Percentage and 100%.

*Applies collectively to all Covered Persons in the same Family.

PREMIUM PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit	Non-PPO Benefit
Inpatient Hospital Services (All related charges) Utilization Review (UR) Notification required or penalty applies.	90% after Deductible	60% after Deductible
Inpatient Hospital Copay per Confinement (applies to each Hospital confinement)	None	$500
Non-compliance Penalty Per Admission (For failure to notify UR Company of Hospital admission.) See Utilization Review Program section.	$1,000	$1,000
Hospital Emergency Room (All related charges) UR Notification required if admitted Inpatient or penalty applies.		
Treatment of Medical Emergency/Accidental Injury	90% after Deductible	90% after Deductible
Treatment of Illness not a Medical Emergency (ER Copay waived if admitted Inpatient)	$150 Copay; then 90% after Deductible	$150 Copay; then 60% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	90% after Deductible	60% after Deductible
Retail Limited Service Clinics (All related lab charges)	100% after $20 Copay	
Helping Hands Clinic (All related lab charges)	100% after $20 Copay	Not Covered
Airrosti Services (Effective May 1, 2012) Office Visit	100% after $20 Copay	
Ambulance Service	90% after Deductible	90% after Deductible
Outpatient Surgery/Ambulatory Surgical Center (All related charges)	90% after Deductible	60% after Deductible
Colonoscopy (diagnostic)	100% after $100 Copay	60% after Deductible
Calendar Year Maximum Benefit	1	
Lab and X-ray Benefit (Procedures performed in Outpatient department of Hospital, free-standing center or independent Facility)	90% after Deductible	60% after Deductible
Physician Office Services Office Visit (Includes examination, treatment, Surgery, lab, x-ray, tests and supplies provided by and billed by Physician at the time of the office visit)	90% after Deductible	60% after Deductible

PREMIUM PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit	Non-PPO Benefit
Allergy Testing, Serum and Injections	90% after Deductible	60% after Deductible
Injectable Hormones (administered in Physician's office)	100% after $100 Copay	60% after Deductible
Voluntary Second Surgical Opinion	90% after Deductible	60% after Deductible
All Other Physician Services	90% after Deductible	60% after Deductible
Maternity (Inpatient Hospital charges and Physician services including prenatal care, delivery and postnatal care) Contact the Utilization Review Company for Coordination of Care.	90% after Deductible	60% after Deductible
Routine Newborn Care (Inpatient Hospital nursery charges and pediatric care to date of mother's discharge) Payable under covered mother's Claim. Baby must be added as a Dependent within **thirty (30) days** of birth to be eligible for this benefit.	90% Deductible waived	60% Deductible waived
Chemotherapy/Radiation Therapy/ Infusion Therapy Contact the Utilization Review Company for Coordination of Care.	90%after Deductible	60% after Deductible
Dialysis UR Notification required.	90% after Deductible	60% after Deductible
Outpatient Cardiac Rehabilitation	90% after Deductible	60% after Deductible
Outpatient Physical Therapy	90% after Deductible	60% after Deductible
Calendar Year Maximum Number of Visits	60	
Outpatient Occupational Therapy	90% after Deductible	60% after Deductible
Calendar Year Maximum Number of Visits	60	
Outpatient Speech Therapy	90% after Deductible	60% after Deductible
Calendar Year Maximum Number of Visits	60	
Durable Medical Equipment (DME)/ Medical Supplies/Prosthetics/Orthotic Devices (not to include Orthotic Insoles)	90% after Deductible	60% after Deductible
Diabetic Self-Management Training	90% after Deductible	60% after Deductible

PREMIUM PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit		Non-PPO Benefit
Temporomandibular Joint (TMJ) Disorders	90% after Deductible		60% after Deductible
Calendar Year Maximum Benefit		$1,000	
Lifetime Maximum Benefit		$5,000	
Sleep Disorders Contact the Utilization Review Company for Coordination of Care. (Covered Services include, office visits, sleep studies/ diagnostic testing, Surgery, devices and equipment)	90% after Deductible		60% after Deductible
Lifetime Maximum Number of Office Visits		25	
Lifetime Maximum Number of Sleep Studies (Diagnostic Testing)		5	
Lifetime Maximum for CPAP		1	
Lifetime Maximum Number of Surgeries		1	
Rehabilitation Facility UR Notification required*	90% after Deductible		60% after Deductible
Skilled Nursing Facility UR Notification required*	90% after Deductible		60% after Deductible
* Notification to the Utilization Review (UR) Company is required within forty-eight (48) hours following admission or penalty applies.			
Maximum Number of Covered Days per Calendar Year		60	
Home Health Care Contact the Utilization Review Company for Coordination of Care.	90% after Deductible		60% after Deductible
Maximum Number of Covered Days per Calendar Year (Applies to part-time or intermittent nursing care visits and therapy services)		60	
Home Infusion Therapy Contact the Utilization Review Company for Coordination of Care.	90% after Deductible		60% after Deductible
Hospice Contact the Utilization Review Company for Coordination of Care.	90% after Deductible		60% after Deductible
Private Duty Nursing Contact the Utilization Review Company for Coordination of Care.	90% after Deductible		60% after Deductible
Maximum Number of Covered Days per Calendar Year		60	

PREMIUM PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit	Non-PPO Benefit
Acupuncture		
City of Rockwall Direct Contracted Providers	90% Deductible waived	Not Covered
Calendar Year Maximum Number of Visits	30	
Chiropractic Services (Includes x-rays)	90% after Deductible	60% after Deductible
Calendar Year Maximum Number of Visits	30	
Mental Disorders, Chemical Dependency, Drug and Substance Abuse		
Inpatient UR Notification required or penalty applies.	90% after Deductible	60% after $500 Copay Deductible applies
Residential Treatment Center/Residential Treatment Center for Children and Adolescents/ Crisis Stabilization Unit UR Notification required or penalty applies.	90% after Deductible	60% after Deductible
Outpatient Day Treatment Facility	90% after Deductible	60% after Deductible
Psychological Testing	90% after Deductible	60% after Deductible
Outpatient Therapy	90% after Deductible	60% after Deductible
Office Visit	90% after Deductible	60% after Deductible

Organ and Tissue Transplants, Donor Expenses
Notify Utilization Review Company upon transplant evaluation for Coordination of Care. (Refer to Organ Transplant Policy section of this Plan Document – Primary payor). See Major Medical Expense Benefits.

PREMIUM PLAN
SCHEDULE OF BENEFITS (Cont'd.)

	PPO Benefit	Non-PPO Benefit
Preventive and Wellness Care Benefits This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam/or as specified below.	100%; Deductible waived	Not Covered

Examples of Covered Wellness Procedures include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. Annual Pap smear and other routine lab
4. Bone Density test (routine, age 60 and older or family history of osteoporosis)
5. Annual PSA test (routine)
6. Well Baby Care Exam/Well Child Care Exam
7. Routine Immunizations
8. Flu vaccine/pneumonia vaccine
9. Routine lab, X-ray, diagnostic testing and other medical screenings
10. Annual Routine Vision Exam (under age 19)
11. Routine Hearing Exam (newborns)
12. Smoking/Tobacco Use Cessation (limited to two (2) Office Visits per Lifetime)
13. All FDA approved women's Contraceptive methods/Sterilization procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

Mammogram		
Age 40 and older (Routine, one per Calendar Year)	100% Deductible waived	Not Covered
Baseline Mammogram (One between ages 35 and 40)	100% Deductible waived	Not Covered
Prior to age 35 (with family history of breast cancer)	90% after Deductible	Not Covered
Routine Colonoscopy Age 50 and older	100% Deductible waived	Not Covered
Age 45-49 (or family history of colon cancer)	90% Deductible waived	Not Covered
Hearing Care Benefit (Including Exam and Hearing Aids)	100% Deductible waived	100% Deductible waived
Lifetime Maximum Hearing Care Benefit Per Covered Person	$2,000	
All Other Covered Medical Expenses, not listed in the Schedule of Benefits are payable at the applicable Benefit Percentage after satisfying the Calendar Year Deductible subject to the Plan Maximums and Limitations.	90% after Deductible	60% after Deductible

PREMIUM PLAN VISION CARE PLAN

	Benefit
Annual Routine Vision Exam	100%; Deductible waived
Calendar Year Maximum Benefit for Exam	$50
Eyeglasses/Contact Lenses (Including fitting of contact lenses)	100%; Deductible waived
Calendar Year Maximum Vision Benefit Per Covered Person for Vision Hardware	$250
NOTE: Vision Expenses for Covered Persons under age 19 are not subject to the Calendar Year Maximum Vision Benefit.	
Vision Expenses for Covered Persons under age 19 also apply to the Annual Out-of-Pocket Maximum.	
Vision Correction Surgery (Lasik and similar procedures)	
Lifetime Maximum Benefit	$500

LIST OF COVERED VISION CARE SERVICES

The following is a complete list of vision care services for which benefits are payable under the Plan. No benefits are payable for a service which is not listed.

1. Vision examination (including refraction)
2. Single vision lenses
3. Bifocal lenses
4. Trifocal lenses
5. Lenticular lenses
6. Frame
7. Tint allowance
8. Contact lenses
9. Fitting of contact lenses
10. Prescription sunglasses

LIMITATIONS

Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. Vision examination more than once in a Calendar Year period;
2. Charges for Vision examinations in excess of the Calendar Year Maximum Benefit;
3. Charges for eyeglasses and contact lenses in excess of the Calendar Year Maximum Benefit;
4. Charges for lasik surgery in excess of the Lifetime Maximum Benefit;
5. Orthoptics or vision training and any associated testing; and
6. Any eye examination, or any corrective eyewear, required by the Employer as a condition of Employment.

PRESCRIPTION DRUG PLAN

Prescription Drug Copays apply to satisfy the Annual Out-of-Pocket Maximum. After the Annual Out-of Pocket Maximum is met, covered Prescription Drugs are payable at 100% for the remainder of the Calendar Year.

Prescription Card Service	**100% after applicable Copay**
Supply Limit	30 days
Generic Drugs (Tier 1)	$10 Copay*
Formulary Brand Name Drugs (Tier 2)	$25 Copay
Non-Formulary Brand Name Drugs (Tier 3)	$40 Copay
Mail Order Service	**100% after applicable Copay**
Supply Limit	90 days
Generic Drugs (Tier 1)	$0 Copay*
Formulary Brand Name Drugs (Tier 2)	$50 Copay
Non-Formulary Brand Name Drugs (Tier 3)	$80 Copay

* Lowest cost Generic Drug

Specialty Pharmacy Drugs**	
Supply Limit	30 days
Generic and Brand Name Drugs	10% Copay to a $150 Maximum Copay per prescription

** All Specialty Pharmacy Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy.

NOTE: Medications required for Preventive Care services may be covered at 100% with no Copay.

If the pharmacy charge is less than the Generic or Brand Copay, then the actual charge will become the Copay. Generic and Brand Name Copayments apply separately to each prescription and refill and do not apply to the Calendar Year Deductible. To be covered, Prescription Drugs must be:

1. Purchased from a participating licensed pharmacist;
2. Dispensed to the Covered Person for whom they are prescribed; and
3. Legally prescribed by a Qualified Prescriber.

Over the Counter (OTC) Claritin, Prilosec, and Over the Counter generic store brands for Claritin and Prilosec are covered for both Plans with a $0 Copay.

DEFINITIONS

Brand Name Drugs (Tier 2 and Tier 3)
Trademark Drugs or substances marketed by the original manufacturer. Tier 2 Drugs are commonly used Brand Name Drugs shown on the Formulary Drug List as "Formulary Alternative(s)." Tier 3 Drugs are Brand Name Drugs listed as "Non-Formulary" or not listed. Brand Name Drugs with Generic alternatives are considered "Non-Formulary."

Generic Drugs (Tier 1)
Drugs or substances which:

1. Are not trademark Drugs or substances; and
2. May be legally substituted for trademark Drugs or substances.

Over the Counter (OTC) Drugs
Drugs which do not require a prescription from a Qualified Prescriber, unless otherwise specified.

SCHEDULE OF DENTAL AND ORTHODONTIC BENEFITS

Dental and Orthodontic Expense Benefits are separate from and in addition to the Medical Expense Benefits of this Plan. These benefits are available only if elected by an Eligible Employee for himself/herself and Eligible Dependents.

MAXIMUM DENTAL BENEFITS	Benefit
Calendar Year Maximum Dental Benefit (Preventive, Basic and Major Services) Per Covered Person	$5,000
Lifetime Maximum Orthodontic Benefit Per Covered Dependent Child	$5,000
DENTAL CALENDAR YEAR DEDUCTIBLE Per Covered Person	$50
BENEFIT PERCENTAGE	
Preventive Dental Services	100%; Deductible waived
Basic Dental Services	80% after Deductible
Major Dental Services	50% after Deductible
Orthodontic Services Benefits limited to Dependent Children under age 19.	50% after Deductible

CALENDAR YEAR DEDUCTIBLE REQUIREMENT

The Covered Person is responsible for the Deductible amount. The Dental Calendar Year Deductible may be satisfied by either Covered Basic Dental Services, Major Dental Services or Orthodontic Services. Payment of Basic, Major and Orthodontic Dental benefits will begin each Calendar Year after the Deductible amount has been satisfied by Covered Charges. The Plan will not reimburse any charges applied to the Deductible.

There is no Deductible carryover for Covered Dental Expenses incurred and applied to the Deductible during the last three (3) months of a Calendar Year.

ALTERNATIVE TREATMENT

This Dental Plan has an "alternative treatment" clause that governs the amount of benefits the Dental Plan will pay for treatments covered under the Dental Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular Amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Customary Charge for an Amalgam filling. The patient will be responsible for the difference in cost.

NOTE: A temporary Dental Service will be considered an integral part of the final dental service rather than a separate service.