CURRENT GROUP HEALTH PLAN EFFECTIVE JANUARY 1, 2007

Benefits	High Option SP 707 2001		Core Option SP 797 5002		Low Option CP 533 5001	
	In Network	Out Of Network	In Network	Out Of Network	In Network	Out Of Network
Deductible						
Individual	None	$300	$500	$1000	$1000	$2000
Family	None	$600	$1000	$2000	$2000	$4000
Out Of Pocket Maximum						
Individual Out of Pocket Maximum	$1500	$3000	$1500	$3000	$2000	$5000
Family Out of Pocket Maximum	$3000	$6000	$3000	$6000	$4000	$10000
Physicians Services	Primary Care Phys / Specialist					
Illness/Injury	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Routine/Preventive Care	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Well-Baby Care	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Hospital Services						
Inpatient	$200 Copay per Admit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	$100 Copay per Visit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
X-Rays/Laboratory	Covered at 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Emergency Room						
Hospital	$75 Copay	$75 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Urgent Care Facility	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay
Mental Health/Substance Abuse						
Inpatient	$200 Copay per Admit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	$15 per Visit	Deductible then 30%	$30 per Visit	Deductible then 30%	$15 per Visit	Deductible then 30%
Prescription Drugs						
Generic	$10 Copay		$10 Copay		$10 Copay	
Brand	$25 Copay		$25 Copay		$25 Copay	
Non Formulary Brand	$40 Copay		$40 Copay		$40 Copay	
Mail Order	2 Copays for 90 day supply		2 Copays for 90 day supply		2 Copays for 90 day supply	
Dependent Age Limits	19 / 23		19 / 23		19 / 23	
COST	County Pays	YOU PAY	County Pays	YOU PAY	County Pays	YOU PAY
Employee Only	358.80 398.80	40.00	358.80 358.80	0.00	321.44 321.44	0.00
Employee & Spouse	358.80 877.68	518.88	358.80 789.35	430.55	358.80 707.18	348.38
Employee & Children	358.80 777.48	418.68	358.80 699.65	340.85	358.80 626.82	268.02
Family	358.80 1138.17	779.37	358.80 1022.57	663.77	358.80 916.11	557.31

UNITED HEALTH CARE EFFECTIVE JANUARY 1, 2008

maximum benefits payable	no max	1,000,000/person	no max	1,000,000/person	no max	1,000,000/person
Benefits	**006 NLF Choice Plus**		**074 EWA Choice Plus**		**MO3 Choice Plus**	
	In Network	Out Of Network	In Network	Out Of Network	In Network	Out Of Network
Deductible						
Individual	None	$300	$500	$1000	$1000	$2000
Family	None	$600	$1000	$2000	$2000	$4000
Out Of Pocket Maximum						
Individual Out of Pocket Maximum	$1500	$3000	$1500	$3000	$2000	$5000
Family Out of Pocket Maximum	$3000	$6000	$3000	$6000	$4000	$10000
Physicians Services	Primary Care Phys / Specialist					
Illness/Injury	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Routine/Preventive Care	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Well-Baby Care	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Chiropractor	$15	Deductible then 30%	$15	Deductible then 30%	$15	Deductible then 30%
Hospital Services						
Inpatient	$200 Copay per Admit	Deductible then 30%	NA per visit	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	Covered at 100%	Deductible then 30%	NA per visit	Deductible then 30%	Deductible then 100%	Deductible then 30%
X-Rays/Laboratory	Covered at 100%	Deductible then 30%	NA per visit	Deductible then 30%	Deductible then 100%	Deductible then 30%
Emergency Room						
Hospital	$75 Copay	$75 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Urgent Care Facility	$50 Copay	$50 Copay	$50 Copay	Deductible then 30%	$50 Copay	$50 Copay
Mental Health/Substance Abuse						
Inpatient	$200 Copay per Admit	Deductible then 30%	NA per visit	Deductible then 30%	100% Coverage After Deductible	Deductible then 30%
Outpatient	$15 per Visit	Deductible then 30%	NA per visit	Deductible then 30%	$15 per Visit	Deductible then 30%
Prescription Drugs						
Generic	$10 Copay		$10 Copay		$10 Copay	
Brand	$25 Copay		$25 Copay		$25 Copay	
Non Formulary Brand	$40 Copay		$40 Copay		$40 Copay	
Mail Order	2-1/2 Copays for 90 day supply		2-1/2 Copays for 90 day supply		2-1/2 Copays for 90 day supply	
Dependent Age Limits	19 / 23		19 / 23		19 / 23	
COST	County Pays	YOU PAY	County Pays	YOU PAY	County Pays	YOU PAY
Employee Only		429.14		386.09		345.90
Employee & Spouse		944.11		849.41		760.98
Employee & Children		836.82		752.88		674.50
Family		1,223.05		1,100.37		985.81

UNITED HEALTH CARE EFFECTIVE JANUARY 1, 2008

single option HRA

maximum benefits payable **Benefits**	**5,000,000/person comb IN & OON** **RTB Choice Plus** In Network	Out Of Network
Deductible		
Individual	2000	4000
Family	4000	8000
Out Of Pocket Maximum		
Individual Out of Pocket Maximum	2000	8000
Family Out of Pocket Maximum	$4000	16000
Physicians Services	Primary Care Phys / Specialist	
Illness/Injury	NA per visit	Deductible then 80%
Routine/Preventive Care	NA per visit	Deductible then 80%
Well-Baby Care	NA per visit	Deductible then 80%
Chiropractor	NA per visit	Deductible then 80%
Hospital Services		
Inpatient	NA per visit	Deductible then 80%
Outpatient	NA per visit	Deductible then 80%
X-Rays/Laboratory	NA per visit	Deductible then 80%
Emergency Room		
Hospital	NA per visit	NA per visit
Urgent Care Facility	NA per visit	Deductible then 80%
Mental Health/Substance Abuse		
Inpatient	NA per visit	Deductible then 80%
Outpatient	NA per visit	Deductible then 80%
Prescription Drugs		
Generic	$10 Copay	
Brand	$30 Copay	
Non Formulary Brand	$50 Copay	
Mail Order	2-1/2 Copays for 90 day supply	
Dependent Age Limits	19 / 23	
COST	County Pays	YOU PAY
Employee Only		308.50
Employee & Spouse		678.70
Employee & Children		601.58
Family		879.23

MERCY HEALTH PLAN EFFECTIVE JANUARY 1, 2008

maximum benefits payable	no max	5,000,000/person	no max	5,000,000/person	no max	5,000,000/person
Benefits	**High Option**		**Core Option**		**Low Option**	
	In Network	Out Of Network	In Network	Out Of Network	In Network	Out Of Network
Deductible						
Individual	None	$300	$500	$1000	$1000	$2000
Family	None	$600	$1000	$2000	$2000	3000
Out Of Pocket Maximum						
Individual Out of Pocket Maximum	None	$3000	None	$3000	None	3000
Family Out of Pocket Maximum	None	$6000	None	$6000	None	6000
Physicians Services	Primary Care Phys / Specialist					
Illness/Injury	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Routine/Preventive Care	0% no ded in network only	Deductible then 30%	0% no ded in network only	Deductible then 30%	0% no ded in network only	Deductible then 30%
Well-Baby Care	0% no ded in network only	Deductible then 30%	0% no ded in network only	Deductible then 30%	0% no ded in network only	Deductible then 30%
Chiro	$15	in network covg only	$30	in network covg only		
Hospital Services						
Inpatient	$200 copay/admission	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	$100 copay/visit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
X-Rays/Laboratory	Ded then 100%/$0 co-pay	Both/Ded then 30%	Ded then 100%/$0 co-pay	Both/Ded then 30%	Ded then 100%/$0 co-pay	Both/Ded then 30%
Emergency Room						
Hospital	$75 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Urgent Care Facility	$50 Copay	Deductible then 30%	$50 Copay	Deductible then 30%	$50 Copay	Deductible then 30%
Mental Health/Substance Abuse						
Inpatient	Deduct then 100%	Deductible then 30%	Deduct then 100%	Deductible then 30%	Deduct then 100%	Deductible then 30%
Outpatient	$15 per Visit	Deductible then 30%	$30 per Visit	Deductible then 30%	$15 per Visit	Deductible then 30%
Prescription Drugs	Mandatory Generic Substitution		Mandatory Generic Substitution		Mandatory Generic Substitution	
Generic tier 1	$10 Copay	50% coinsurance	$10 Copay	50% coinsurance	$10 Copay	50% coinsurance
Brand tier 2	$25 Copay	50% coinsurance	$25 Copay	50% coinsurance	$25 Copay	50% coinsurance
Non Formulary Brand tier 3	$40 Copay	50% coinsurance	$40 Copay	50% coinsurance	$40 Copay	50% coinsurance
Mail Order	2 Copay for 90 day supply	not covered	2 Copay for 90 day supply	not covered	2 Copay for 90 day supply	not covered
tier 4	20% up to $100 copay	50% coinsurance	20% up to $100 copay	50% coinsurance	20% up to $100 copay	50% coinsurance
Dependent Age Limits	19 / 23		19 / 23		19 / 23	
COST	County Pays	YOU PAY	County Pays	YOU PAY	County Pays	YOU PAY
Employee Only		486.65		437.82		392.12
Employee & Spouse		1,071.13		963.64		863.06
Employee & Children		948.98		853.75		764.63
Family		1,388.91		1,249.54		1,119.11

GROUP HEALTH PLAN EFFECTIVE JANUARY 1, 2008

maximum benefits payable	no max	1,000,000	no max	1,000,000	no max	1,000,000
Benefits	**High Option SP 707 2001**		**Core Option SP 797 5002**		**Low Option CP 533 5001**	
	In Network	Out Of Network	In Network	Out Of Network	In Network	Out Of Network
Deductible						
Individual	None	$300	$500	$1000	$1000	$2000
Family	None	$600	$1000	$2000	$2000	$4000
Out Of Pocket Maximum						
Individual Out of Pocket Maximum	$1500	$3000	$1500	$3000	$2000	$5000
Family Out of Pocket Maximum	$3000	$6000	$3000	$6000	$4000	$10000
Physicians Services	Primary Care Phys / Specialist					
Illness/Injury	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Routine/Preventive Care	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Well-Baby Care	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Hospital Services						
Inpatient	$200 Copay per Admit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	$100 Copay per Visit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
X-Rays/Laboratory	Covered at 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Emergency Room						
Hospital	$75 Copay	$75 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Urgent Care Facility	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay
Mental Health/Substance Abuse						
Inpatient	$200 Copay per Admit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	$15 per Visit	Deductible then 30%	$30 per Visit	Deductible then 30%	$15 per Visit	Deductible then 30%
Prescription Drugs						
Generic	$10 Copay		$10 Copay		$10 Copay	
Brand	$25 Copay		$25 Copay		$25 Copay	
Non Formulary Brand	$40 Copay		$40 Copay		$40 Copay	
Mail Order	2 Copays for 90 day supply		2 Copays for 90 day supply		2 Copays for 90 day supply	
Dependent Age Limits	19 / 23		19 / 23		19 / 23	
COST	County Pays	YOU PAY	County Pays	YOU PAY	County Pays	YOU PAY
Employee Only		432.80		389.35		348.82
Employee & Spouse		952.51		856.56		767.41
Employee & Children		843.75		759.23		680.21
Family		1,235.22		1,109.64		994.15

GROUP HEALTH PLAN EFFECTIVE JANUARY 1, 2008

maximum benefits payable	no max	1,000,000	no max	1,000,000	no max	1,000,000
Benefits	**POS 555**		**POS 610**		**POS 611**	
	In Network	Out Of Network	In Network	Out Of Network	In Network	Out Of Network
Deductible						
Individual	$1000	$2000	$2000	$4000	$2500	$5000
Family	$2000	$4000	$4000	$8000	$5000	$10000
Out Of Pocket Maximum						
Individual Out of Pocket Maximum	$2000	$4000	$4000	$8000	$5000	$10000
Family Out of Pocket Maximum	$4000	$8000	$8000	$16000	$10000	$20000
Physicians Services	Primary Care Phys / Specialist					
Illness/Injury	$20/$40	Deductible then 30%	$20/$40	Deductible then 30%	$20/$40	Deductible then 30%
Routine/Preventive Care	$20/$40	Deductible then 30%	$20/$40	Deductible then 30%	$20/$40	Deductible then 30%
Well-Baby Care	$20/$40	Deductible then 30%	$20/$40	Deductible then 30%	$20/$40	Deductible then 30%
Chiro	$40	Deductible then 30%	$40	Deductible then 30%	$40	Deductible then 30%
Hospital Services						
Inpatient	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 90%	Deductible then 30%
Outpatient	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 90%	Deductible then 30%
X-Rays/Laboratory	$0 copay	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 90%	Deductible then 30%
Emergency Room						
Hospital	$100 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Urgent Care Facility	$50 Copay	30% coinsurance/visit	$50 Copay	$50 Copay	$50 Copay	$50 Copay
Mental Health/Substance Abuse						
Inpatient	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 90%	Deductible then 30%
Outpatient	$40 per Visit	Deductible then 30%	$40 per Visit	Deductible then 30%	$40 per Visit	Deductible then 30%
Prescription Drugs						
Generic	$10 Copay		$10 Copay		$10 Copay	
Brand	$25 Copay		$25 Copay		$25 Copay	
Non Formulary Brand	$40 Copay		$40 Copay		$40 Copay	
Mail Order	2 Copays for 90 day supply		2 Copays for 90 day supply		2 Copays for 90 day supply	
Dependent Age Limits	19 / 23		19 / 23		19 / 23	
COST	County Pays	YOU PAY	County Pays	YOU PAY	County Pays	YOU PAY
Employee Only		366.90		332.65		308.89
Employee & Spouse		807.47		732.10		679.79
Employee & Children		715.27		648.51		602.17
Family		1,047.12		949.39		881.56

GROUP HEALTH PLAN EFFECTIVE JANUARY 1, 2008

maximum benefits payable	no max	1,000,000	no max	1,000,000	no max	1,000,000
Benefits	**PPO 108**		**PPO 121**		**PPO 110**	
	In Network	Out Of Network	In Network	Out Of Network	In Network	Out Of Network
Deductible						
Individual	$250	$500	$1000	$2000	$500	$1000
Family	$500	$1000	$2000	$4000	$1000	$2000
Out Of Pocket Maximum						
Individual Out of Pocket Maximum	$1500	$3000	$2000	$4000	$1500	$3000
Family Out of Pocket Maximum	$3000	$6000	$4000	$8000	$3000	$6000
Physicians Services	Primary Care Phys / Specialist					
Illness/Injury	$15 / $30	Deductible then 30%	$20/$40	Deductible then 30%	$15 / $30	Deductible then 30%
Routine/Preventive Care	$15 / $30	Deductible then 30%	$20/$40	Deductible then 30%	$15 / $30	Deductible then 30%
Well-Baby Care	$15 / $30	Deductible then 30%	$20/$40	Deductible then 30%	$15 / $30	Deductible then 30%
Chiro	$30	Deductible then 30%	$40	Deductible then 30%	$30	Deductible then 30%
Hospital Services						
Inpatient	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Covered at 100%	Deductible then 30%
Outpatient	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
X-Rays/Laboratory	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Emergency Room						
Hospital	$75 Copay	$75 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Urgent Care Facility	$50 Copay	$50 Copay	$50 Copay	$50 Copay	$50 Copay	Deductible then 30%
Mental Health/Substance Abuse						
Inpatient	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	$30 per Visit	Deductible then 30%	$40 per Visit	Deductible then 30%	$30 per Visit	Deductible then 30%
Prescription Drugs						
Generic	$10 Copay		$10 Copay		$10 Copay	
Brand	$25 Copay		$25 Copay		$25 Copay	
Non Formulary Brand	$40 Copay		$40 Copay		$40 Copay	
Mail Order	2 Copays for 90 day supply		2 Copays for 90 day supply		2 Copays for 90 day supply	
Dependent Age Limits	19 / 23		19 / 23		19 / 23	
COST	County Pays	YOU PAY	County Pays	YOU PAY	County Pays	YOU PAY
Employee Only		338.56		305.23		326.17
Employee & Spouse		745.10		671.76		717.84
Employee & Children		660.02		595.05		635.88
Family		966.25		871.14		930.90

ANTHEM (BC/BS) HEALTH PLAN EFFECTIVE JANUARY 1, 2008

maximum benefits payable	no max	no max	no max	no max	no max	no max
Benefits	**Option 1**		**Option 2**		**Option 3**	
	In Network	Out Of Network	In Network	Out Of Network	In Network	Out Of Network
Deductible						
Individual	None	$300	$500	$1000	$1000	$2000
Family	None	$600	$1000	$2000	$2000	$4000
Out Of Pocket Maximum						
Individual Out of Pocket Maximum	$1500	$3000	$1500	$3000	$2000	$5000
Family Out of Pocket Maximum	$3000	$6000	$3000	$6000	$4000	$10000
Physicians Services	Primary Care Phys / Specialist					
Illness/Injury	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Routine/Preventive Care	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Well-Baby Care	$15 / $15	Deductible then 30%	$15 / $30	Deductible then 30%	$15 / $15	Deductible then 30%
Hospital Services						
Inpatient	$200 Copay per Admit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	$100 Copay per Visit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
X-Rays/Laboratory	Covered at 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Emergency Room						
Hospital	$75 Copay	$75 Copay	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Urgent Care Facility	$50 Copay	Deductible then 30%	$50 Copay	Deductible then 30%	$50 Copay	Deductible then 30%
Mental Health/Substance Abuse						
Inpatient	$200 Copay per Admit	Deductible then 30%	Deductible then 100%	Deductible then 30%	Deductible then 100%	Deductible then 30%
Outpatient	$15 / $30 per Visit	Deductible then 30%	$15 / $30 per Visit	Deductible then 30%	$15 / $30 per Visit	Deductible then 30%
Prescription Drugs						
Generic	8--$10 Copay		8--$10 Copay		8--$10 Copay	
Brand	25--$25 Copay		25--$25 Copay		25--$25 Copay	
Non Formulary Brand	45--$40 Copay		45--$40 Copay		45--$40 Copay	
Mail Order	2 Copays for 90 day supply		2 Copays for 90 day supply		2 Copays for 90 day supply	
Dependent Age Limits	19 / 24		19 / 24		19 / 24	
COST	County Pays	YOU PAY	County Pays	YOU PAY	County Pays	YOU PAY
Employee Only		426.00		383.27		343.36
Employee & Spouse		937.54		843.18		755.41
Employee & Children		830.50		747.37		669.57
Family		1,215.80		1,092.31		978.59