

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	\$5,000,000	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	N/A	\$100
Per Family Unit	N/A	\$200 or two persons
COINSURANCE	100%	90%
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Family Unit	N/A	\$1,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Deductible(s) Cost containment penalties Copayments Outpatient mental health charges		
COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospital Services		
Room and Board	100% the semiprivate room rate	100% of Reasonable and Customary Charges the semiprivate room rate
Intensive Care Unit	100% Hospital's ICU Charge	100% of Reasonable and Customary Charges Hospital's ICU Charge
Skilled Nursing Facility	100% the facility's semiprivate room rate within 14 days of a Hospital admission	100% of Reasonable and Customary Charges the facility's semiprivate room rate within 14 days of a Hospital admission
	730 days combined per Calendar Year maximum Renew when patient is out of the Hospital or Facility for 60 days	
Physician Services		
Inpatient visits	100%	100% of Reasonable and Customary Charges
Office visits (Routine office visits are not covered)	100%	90% of Reasonable and Customary Charges
Surgery	100%	100% of Reasonable and Customary Charges
Allergy testing	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Allergy serum and injections	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Home Health Care	100%	100% of Reasonable and Customary Charges
	30 days combined per Calendar Year maximum	

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Inpatient Prescription Drugs	100%	100% of Reasonable and Customary Charges after deductible and coinsurance
Outpatient Private Duty Nursing	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Hospice Care	100%	100% of Reasonable and Customary Charges
		\$5,000 combined inpatient and outpatient Lifetime maximum
Ambulance Service	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Jaw Joint/TMJ	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
		\$450 combined per Lifetime maximum
Occupational Therapy	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Speech Therapy	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Physical Therapy	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Durable Medical Equipment	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Prosthetics	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Orthotics	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Spinal Manipulation Chiropractic	100%	90% of Reasonable and Customary Charges after deductible and coinsurance
Mental Disorders		
Inpatient	100%	100% of Reasonable and Customary Charges
		45 days combined per Calendar Year maximum
Outpatient	100%	90% of Reasonable and Customary Charges
		45 days combined per Calendar Year maximum
Substance Abuse		
Inpatient	100%	100% of Reasonable and Customary Charges
		45 days combined per Calendar Year maximum
Outpatient	100%	90% of Reasonable and Customary Charges
		35 days combined per Calendar Year maximum 140 visits combined per Lifetime maximum

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Preventive Care		
Routine Well Adult Care (Cancer Screenings, does not include office visits)	100%, not subject to office visit copayment	90% of Reasonable and Customary Charges after deductible and coinsurance
Includes: pap smear, mammogram, prostate screening, gynecological exam, colon and rectum.		
Frequency limits for mammogram Ages 35 – 39..... One baseline mammogram Ages 40 – 49..... One every two years Ages 50 and over..... One mammogram per Calendar Year		
Inpatient Routine Well Newborn Care	100%	100% of Reasonable and Customary Charges after deductible and coinsurance
Routine Well Child Care (Does not include office visits)	100%	90% of Reasonable and Customary Charges
Includes: Immunizations and injections.		
Organ Transplants	100%	100% of Reasonable and Customary Charges
	\$1,000,000 for each type of transplant per Lifetime maximum	
Medical Weight Loss (Only for Morbid Obesity)	100% Plan covers up to \$625	90% of Reasonable and Customary Charges after deductible and coinsurance Plan covers up to \$625
Pregnancy	100%	100% of Reasonable and Customary Charges

PRESCRIPTION DRUG EXPENSE BENEFITS

Pharmacy Option

Generic drugs

Copayment..... \$5.00

Brand Name drugs

Copayment..... \$10.00

Mail Order Prescription Drug Option (One copayment for 90 days)

Generic drugs

Copayment..... \$2.00

Brand Name drugs

Copayment..... \$5.00

SCHEDULE OF VISION BENEFITS

Vision Examination	Reasonable and Customary Charges \$49.50 Maximum Amount
Corrective Lenses (Each)	Reasonable and Customary Charges According to the Fee Schedule
<ul style="list-style-type: none"> • Single Vision • Bi-Focal • Tri-Focal • Lenticular 	
Frames	Reasonable and Customary Charges, \$100.00 Maximum Amount
Contact Lenses (Including the Exam)	\$200.00 Maximum Amount
Necessary Cosmetic (Elective)	\$130.00 Maximum Amount

Please Note: For each plan year, charges for contact lenses and the examination are in lieu of all other covered charges during the plan year for each Covered Person.

Benefit year for vision is January 1st through December 31st.

SCHEDULE OF DENTAL EXPENSE BENEFITS

PLAN A

The following Schedule of Dental Expense Benefits is applicable to those Employees without dental coverage through another source:

Class I Benefits	100% of Reasonable and Customary Charges
(diagnostic, preventive & emergency palliative)	
Class I Benefits	90% of Reasonable and Customary Charges
(balance of Class I Benefits including radiographs)	
Class II Benefits	90% of Reasonable and Customary Charges
(prosthodontic dental services)	
Class III Benefits	90% of Reasonable and Customary Charges
(orthodontic dental services to age 19)	
Individual Maximum per Benefit Year for Class I & II.....	\$1,000.00
Lifetime Individual Maximum for Class III Benefits	\$1,500.00

PLAN B

The following Schedule of Dental Expense Benefits is applicable to those Employees who have Dental Coverage through another source:

Class I Benefits	50% of Reasonable and Customary Charges
(basic dental services)	
Class II Benefits	50% of Reasonable and Customary Charges
(prosthodontic dental services)	
Class III Benefits	50% of Reasonable and Customary Charges
(orthodontic dental services to age 19)	
Individual Maximum per Benefit Year for Class I & II.....	\$1,000.00
Lifetime Individual Maximum for Class III Benefits	\$1,000.00

Please Note: Benefit Plan Year for Dental is January 1st to December 31st.

**Second Amendment To The
TROY SCHOOL DISTRICT – NON-REP Employees
Health Care Plan**

This Second Amendment to the Troy School District Health Care Plan (the "Plan") is adopted by Troy School District (the "Company") effective July 1, 2007 with reference to the following:

The Company adopted a Health Care Plan for its employees reinstated January 1, 2004.

NOW THEREFORE, the Plan is amended as follows:

The Express-Scripts Prescription Copays will change as follows:

\$5.00 copay for Generic Prescriptions at Retail

\$20.00 copay for Brand Name Prescriptions at Retail

\$5.00 copay for Generic Prescriptions at Mail Order for a 3 month supply

\$20.00 copay for Brand Name Prescriptions at Mail Order for a 3 month supply

IN WITNESS THEREOF, the parties have caused this Amendment to be adopted this 25 day
of May, 2007.

COMPANY: TROY SCHOOL DISTRICT

By: Maurice B. Kelly

Its: Asst. Supt. for Human Resources