

**Benefit Comparison for:
MARIETTA COLLEGE**

Effective: January 1, 2009

BENEFITS	Plus		Standard		Basic	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Benefit Period	Jan 1 through Dec 31 (CY)		Jan 1 through Dec 31 (CY)		Jan 1 through Dec 31 (CY)	
Carry-Over Deductible	Oct, Nov & Dec		Oct, Nov & Dec		Oct, Nov & Dec	
Dependent Age Limitations	End of calendar year of age 19, but will continue to the end of the calendar year of age 24 if child qualifies as a federal tax exemption.					
Deductible (Calendar Year) (Family may be met collectively)	\$250 Single \$500 Family	\$500 Single \$1,000 Family	\$1,000 Single \$2,000 Family	\$2,000 Single \$4,000 Family	\$2,500 Single \$5,000 Family	\$5,000 Single \$10,000 Family
Coinsurance (Calendar Year) (Family may be met collectively)	\$1,750 Single \$3,500 Family	\$3,500 Single \$7,000 Family	\$3,000 Single \$6,000 Family	\$6,000 Single \$12,000 Family	\$2,500 Single \$5,000 Family	\$5,000 Single \$10,000 Family
Out-Of-Pocket Limit (Including Deductible per Calendar Year) (Family may be met collectively)	\$2,000 Single \$4,000 Family	\$4,000 Single \$8,000 Family	\$4,000 Single \$8,000 Family	\$8,000 Single \$16,000 Family	\$5,000 Single \$10,000 Family	\$10,000 Single \$20,000 Family
Pre-Existing Conditions - New Hires	Subject to HIPAA Regulations		Subject to HIPAA Regulations		Subject to HIPAA Regulations	
BENEFIT SERVICES (Note: All benefits listed with a percentage % copay are subject to deductible unless noted otherwise).						
Physician Office Visits:						
Primary Care Physician (PCP)	\$25 CoPay	60%	\$25 CoPay	50%	\$25 CoPay	50%
Specialty Care Physician (SCP)	\$25 CoPay	60%	\$25 CoPay	50%	\$25 CoPay	50%
Office Surgeries	\$25 CoPay	60%	\$25 CoPay	50%	\$25 CoPay	50%
Allergy Serum (PCP and SCP)	\$25 CoPay	60%	\$25 CoPay	50%	\$25 CoPay	50%
Allergy Testing	80%	60%	80%	50%	70%	50%
Allergy Injections (No Office Visit)	\$5 CoPay	60%	\$5 CoPay	50%	\$5 CoPay	50%
Routine & Non-Routine Mammograms (regardless of outpatient setting)	\$25 CoPay	60%	\$25 CoPay	50%	\$25 CoPay	50%
Diabetic Education	\$25 CoPay	60%	\$25 CoPay	50%	\$25 CoPay	50%
Certain Medical Nutritional Therapy	\$25 CoPay	Not Covered	\$25 CoPay	Not Covered	\$25 CoPay	Not Covered
MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies & Non-Maternity Ultrasounds	80%	60%	80%	50%	70%	50%
Preventive Care Services:						
Routine PAP, Mammogram & PSA	* Copayment based on place of service		* Copayment based on place of service		* Copayment based on place of service	
Immunizations ⁽¹⁾	* Copayment based on place of service		* Copayment based on place of service		* Copayment based on place of service	
Annual Diabetic Eye Exam	* Copayment based on place of service		* Copayment based on place of service		* Copayment based on place of service	
Routine Vision & Hearing Exam	* Copayment based on place of service		* Copayment based on place of service		* Copayment based on place of service	
Place of Service:						
* Physician Home & Office Visits	\$25 CoPay	60%	\$25 CoPay	50%	\$25 CoPay	50%
* Other Outpatient Services @ Hospital/Alternative Care Facility	80%	60%	80%	50%	70%	50%
Maternity Services	80%	60%	80%	50%	70%	50%
Newborn Exam	80%	60%	80%	50%	70%	50%
Urgent Care Center Services	\$35 CoPay	\$35 CoPay	\$35 CoPay	\$35 CoPay	\$35 CoPay	\$35 CoPay

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BENEFIT SERVICES (Note: All benefits listed with a percentage % copay are subject to deductible unless noted otherwise). - Continued						
Emergency Care @ Hospital Facility/Other Covered Services	\$75 CoPay (waived if admitted)	\$75 CoPay (waived if admitted)	\$75 CoPay (waived if admitted)	\$75 CoPay (waived if admitted)	\$75 CoPay (waived if admitted)	\$75 CoPay (waived if admitted)
Ambulance Services	80%	80%	80%	80%	70%	70%
Inpatient and Outpatient Professional Services	80%	60%	80%	50%	70%	50%
Inpatient Facility Services:	80%	60%	80%	50%	70%	50%
Semi-Private Room and Board	Unlimited Days	Combined with Network	Unlimited Days	Combined with Network	Unlimited Days	Combined with Network
Physical Medicine/Rehabilitation	60 Days	Combined with Network	60 Days	Combined with Network	60 Days	Combined with Network
Skilled Nursing Facility	90 Days	Combined with Network	90 Days	Combined with Network	90 Days	Combined with Network
Physical Medicine Therapy Day Rehabilitation Programs	80%	60%	80%	50%	70%	50%
	(Included in Limit for Physical Medicine/Rehabilitation)		(Included in Limit for Physical Medicine/Rehabilitation)		(Included in Limit for Physical Medicine/Rehabilitation)	
Outpatient Surgery Hospital or Alternative Care Facility	80%	60%	80%	50%	70%	50%
Other Outpatient Services:						
Non-Surgical Outpatient Services (MRI, C-Scan, Chemo, Ultrasound & Outpatient Diagnostic Services)	80%	60%	80%	50%	70%	50%
Home Care Services	80%	60%	80%	50%	70%	50%
(Limit excludes IV Therapy)	90 Visits	Combined with Network	90 Visits	Combined with Network	90 Visits	Combined with Network
Hospice Care Services	80%	80%	80%	80%	70%	70%
Durable Medical Equipment, Orthotics & Prosthetic Devices	80%	60%	80%	50%	70%	50%
Outpatient Therapy Services:	* Copayment based on place of service		* Copayment based on place of service		* Copayment based on place of service	
Physical Therapy	30 Visits	Combined with Network	30 Visits	Combined with Network	30 Visits	Combined with Network
Occupational Therapy	30 Visits	Combined with Network	30 Visits	Combined with Network	30 Visits	Combined with Network
Spinal Manipulations	12 Visits	Combined with Network	12 Visits	Combined with Network	12 Visits	Combined with Network
Speech Therapy	20 Visits	Combined with Network	20 Visits	Combined with Network	20 Visits	Combined with Network
Place of Service:						
* Physician Home & Office Visits	\$25 CoPay	60%	\$25 CoPay	50%	\$25 CoPay	50%
* Other Outpatient Services @ Hospital/Alternative Care Facility	80%	60%	80%	50%	70%	50%
Behavioral Health Services:						
Non Biologically based Mental Illness and Substance Abuse ⁽²⁾ Limits apply.						
Inpatient	80%; 30 Days	60%; Comb. with Network	80%; 30 Days	50%; Comb. with Network	70%; 30 Days	50%; Comb. with Network
Outpatient (Inpatient & Outpatient Substance Abuse \$550 Non-Network)	* Copayment based on place of service 50 Visits	10 Visits	* Copayment based on place of service 50 Visits	10 Visits	* Copayment based on place of service 50 Visits	10 Visits
Substance Abuse Rehabilitation	2 per Lifetime Network & Non-Network Combined		2 per Lifetime Network & Non-Network Combined		2 per Lifetime Network & Non-Network Combined	
Biologically based Mental Illness	Paid same as any other illness.		Paid same as any other illness.		Paid same as any other illness.	

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Human Organ & Tissue Transplant: Acquisition & transplant procedures, harvest & storage.	100%; No Deductible	50% Note: Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.	100%; No Deductible	50%	100%; No Deductible	50%
Lifetime Maximum	\$5,000,000 Combined Network and Non-Network		\$5,000,000 Combined Network and Non-Network		\$5,000,000 Combined Network and Non-Network	
Prescription Drugs⁽⁴⁾						
Network Retail Pharmacies: (30 day supply)	\$12 Generic \$24 Formulary \$40 Non-Formulary	50%; min \$40 ⁽³⁾ 50%; min \$40 ⁽³⁾ 50%; min \$40 ⁽³⁾	\$12 Generic \$24 Formulary \$40 Non-Formulary	50%; min \$40 ⁽³⁾ 50%; min \$40 ⁽³⁾ 50%; min \$40 ⁽³⁾	\$12 Generic \$24 Formulary \$40 Non-Formulary	50%; min \$40 ⁽³⁾ 50%; min \$40 ⁽³⁾ 50%; min \$40 ⁽³⁾
Anthem Rx Direct Mail Service: (90 day supply)	\$24 Generic \$48 Formulary \$80 Non-Formulary	NA NA NA	\$24 Generic \$48 Formulary \$80 Non-Formulary	NA NA NA	\$24 Generic \$48 Formulary \$80 Non-Formulary	NA NA NA
Specialty Medications:	Must be obtained via Anthem's Specialty Pharmacy Network in order to receive network level benefits.					

NOTE: This Schedule of Benefits is intended to provide an overview of benefits offered; please refer to your Certificate of Coverage for complete benefit information.

- * Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug copayments and Non-Network Human Organ and Tissue Transplants are excluded from the out-of-pocket.
- * Network and Non-Network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.
- * Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- * PCP is a Network Provider who specializes in family practice, general practice, internal medicine, pediatrics, Obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the plan.
- * SPC is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- * Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at Network pharmacies including diabetic test strips. (Exception)
- * Office visits include all office visits (Physician office, Preventive, MH/SA and Urgent Care Services) count toward out-of-pocket maximums.
- * Elective abortions are excluded from coverage.

- (1) These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
- (2) We encourage you to contact Anthem's Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to schedule of benefits for limitations.
- (3) Rx Non-Network diabetic/asthmatic supplies not covered except diabetic test strips.
- (4) Prescription Drugs do not count toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.