

Northside ISD Benefits Eff. January 1, 2008

Employee Share of Monthly Premium

Employee Only	\$10.00	\$32.28	\$61.84	\$251.02
Employee & Spouse	\$249.60	\$302.88	\$373.54	\$825.62
Employee & Children	\$152.56	\$192.24	\$244.86	\$581.58
Employee & Family	\$250.36	\$310.30	\$389.82	\$898.68

Network	Humana Preferred (HPN)		Humana Preferred (HPN)		Humana Preferred (HPN)		Humana HMO
	CoverageFirst 1000		PPO 500		PPO 300		HMO 1
(This is a partial list of benefits. See separate Benefit Summary for each plan for more specific details.)	Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers	Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers	Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers	Plan pays for services from PARTICIPATING providers
Up-front Benefit Allowance Annual member benefit (per calendar year) (1)	\$500	N/A	N/A	N/A	N/A	N/A	N/A
Preventative Care Annual routine physical exam and routine child care Routine mammogram Routine lab and X-ray	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible	100% after \$15 primary care physician or \$30 specialist copayment per visit
Vision Exam	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Physician Services Office visits and prenatal care (2)	100% after \$20 primary care physician or \$35 specialist copayment per visit (excludes diagnostic lab and X-ray, outpatient surgery)	70% after deductible	100% after \$25 primary care physician or \$40 specialist copayment per visit (excludes outpatient surgery)	70% after deductible	100% after \$20 primary care physician or \$35 specialist copayment per visit (excludes outpatient surgery)	70% after deductible	100% after \$15 primary care physician or \$30 specialist copayment per visit
Diagnostic test, lab and X-rays (performed in the physician's office)	80% after deductible	60% after deductible	100% after \$25 primary care physician or \$40 specialist copayment per visit	70% after deductible	100% after \$20 primary care physician or \$35 specialist copayment per visit	70% after deductible	100% after \$15 primary care physician or \$30 specialist copayment per visit
Allergy injections	100% after \$5 copayment per visit	70% after deductible	100% after \$5 copayment per visit	70% after deductible	100% after \$5 copayment per visit	70% after deductible	100% after \$5 copay per visit
Inpatient/outpatient services Emergency room visits Allergy serum	80% after deductible	60% after deductible	80% after deductible	50% after deductible	90% after deductible	70% after deductible	Appropriate Copay Applies
Hospital Services Inpatient care (3)	100% after \$100 copayment per day for first five days per admission, and after deductible (3)	70% after deductible	100% after \$250 copayment per day for first five days per admission, and after deductible (3)	70% after deductible	100% after \$150 copayment per day for first five days per admission, and after deductible (3)	70% after deductible	100% after \$100 copayment per day for first five days per admission (3)
Outpatient surgery	100% after \$50 copayment per procedure, and after deductible	70% after deductible	100% after \$100 copayment per procedure, and after deductible	70% after deductible	100% after \$50 copayment per procedure, and after deductible	70% after deductible	100% after \$50 copayment per visit
Outpatient nonsurgical care (including diagnostic lab and X-ray)	80% after deductible	60% after deductible	80% after deductible	50% after deductible	90% after deductible	60% after deductible	100%
Emergency room	100% after \$100 copayment per visit, and after deductible (copayment waived if admitted)	70% after deductible	100% after \$150 copayment per visit, and after deductible (copayment waived if admitted)	70% after deductible	100% after \$100 copayment per visit, and after deductible (copayment waived if admitted)	70% after deductible	100% after \$75 copayment per visit (copayment waived if admitted)
Other Medical Services Physical, speech and hearing therapy	80% after deductible	60% after deductible	80% after deductible	50% after deductible	90% after deductible	60% after deductible	100% after \$30 copayment per visit
Prescription Drugs Rx4 Coverage	\$10/25/45/25% / Mail order 2x retail copay		\$10/25/45/25% / Mail order 2x retail copay		\$10/25/45/25% / Mail order 2x retail copay		\$10/25/45/25% / Mail order 2x retail copay
Annual Deductibles (per calendar year)							
Individual	\$1,000	\$2,000	\$500	\$1,000	\$300	\$600	N/A
Family	\$3,000	\$6,000	\$1,500	\$3,000	\$900	\$1,800	N/A
Out-Of-Pocket Amounts (per calendar year) (4)							
Individual	\$2,000	\$4,000	\$3,000	\$6,000	\$2,500	\$5,000	\$2,000
Family	\$6,000	\$12,000	\$9,000	\$18,000	\$7,500	\$15,000	\$6,000
Lifetime Maximum	\$5,000,000		\$5,000,000		\$5,000,000		NA

NOTE: For Mental Health Services, see separate Benefit Summary.

(1) Applies to medical services received from participating providers only. Does not apply to member copayments, mental health services or pharmacy benefits. (2) Prenatal copayment applies to first visit only.
 (3) Inpatient copayment is charged each day for first five days of each admission for the plans where copayment applies. (4) PPO out-of-pocket amounts exclude copayments and deductibles.

Northside ISD Benefits Eff. January 1, 2008

ChoiceCare Network

Employee Share of Monthly Premium

Employee Only	\$60.88	\$87.40	\$122.58
Employee & Spouse	\$371.22	\$434.62	\$518.70
Employee & Children	\$243.14	\$290.36	\$352.96
Employee & Family	\$387.24	\$458.56	\$553.20

Network	Humana Preferred (CHC)		Humana Preferred (CHC)		Humana Preferred (CHC)	
	CoverageFirst 1000		PPO 500		PPO 300	
	Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers	Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers	Plan pays for services from PARTICIPATING providers	Plan pays for services from NONPARTICIPATING providers
Up-front Benefit Allowance Annual member benefit (per calendar year) (1)	\$500	N/A	N/A	N/A	N/A	N/A
Preventive Care Annual routine physical exam and routine child care	100% after \$20 primary care physician or \$35 specialist copayment per visit	70% after deductible	100% after \$25 primary care physician or \$40 specialist copayment per visit	70% after deductible	100% after \$20 primary care physician or \$35 specialist copayment per visit	70% after deductible
Routine mammogram Routine lab and X-ray	100%	70% after deductible	100%	70% after deductible	100%	70% after deductible
Vision Exam	N/A	N/A	N/A	N/A	N/A	N/A
Physician Services Office visits and prenatal care (2)	100% after \$20 primary care physician or \$35 specialist copayment per visit (excludes diagnostic lab and X-ray, outpatient surgery)	70% after deductible	100% after \$25 primary care physician or \$40 specialist copayment per visit (excludes outpatient surgery)	70% after deductible	100% after \$20 primary care physician or \$35 specialist copayment per visit (excludes outpatient surgery)	70% after deductible
Diagnostic test, lab and X-rays (performed in the physician's office)	80% after deductible	60% after deductible	100% after \$25 primary care physician or \$40 specialist copayment per visit	70% after deductible	100% after \$20 primary care physician or \$35 specialist copayment per visit	70% after deductible
Allergy injections	100% after \$5 copayment per visit	70% after deductible	100% after \$5 copayment per visit	70% after deductible	100% after \$5 copayment per visit	70% after deductible
Inpatient/outpatient services Emergency room visit Allergy serum	80% after deductible	60% after deductible	80% after deductible	50% after deductible	90% after deductible	70% after deductible
Hospital Services Inpatient care (3)	100% after \$100 copayment per day for first five days per admission, and after deductible (3)	70% after deductible	100% after \$250 copayment per day for first five days per admission, and after deductible (3)	70% after deductible	100% after \$150 copayment per day for first five days per admission, and after deductible (3)	70% after deductible
Outpatient surgery	100% after \$50 copayment per procedure, and after deductible	70% after deductible	100% after \$100 copayment per procedure, and after deductible	70% after deductible	100% after \$50 copayment per procedure, and after deductible	70% after deductible
Outpatient nonsurgical care (including diagnostic lab and X-ray)	80% after deductible	60% after deductible	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Emergency room	100% after \$100 copayment per visit, and after deductible (copayment waived if admitted)	70% after deductible	100% after \$150 copayment per visit, and after deductible (copayment waived if admitted)	70% after deductible	100% after \$100 copayment per visit, and after deductible (copayment waived if admitted)	70% after deductible
Other Medical Services Physical, speech and hearing therapy	80% after deductible	60% after deductible	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Prescription Drugs Rx4 Coverage	\$10/25/45/25% / Mail order 2x retail copay		\$10/25/45/25% / Mail order 2x retail copay		\$10/25/45/25% / Mail order 2x retail copay	
Annual Deductibles (per calendar year)						
Individual	\$1,000	\$2,000	\$500	\$1,000	\$300	\$600
Family	\$3,000	\$6,000	\$1,500	\$3,000	\$900	\$1,800
Out-Of-Pocket Amounts (per calendar year) (4)						
Individual	\$2,000	\$4,000	\$3,000	\$6,000	\$2,500	\$5,000
Family	\$6,000	\$12,000	\$9,000	\$18,000	\$7,500	\$15,000
Lifetime Maximum	\$5,000,000		\$5,000,000		\$5,000,000	

NOTE: For Mental Health Services, see separate Benefit Summary.

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