SUMMITT TRUCKING
2007 HEALTH PLAN COVERAGES AND COSTS

BENEFITS	**ENHANCED PLAN**		**PREFERRED PLAN**		**STANDARD PLAN**	
OFFICE VISIT	$25 PCP /$40 SPC		$25 PCP /$40 SPC		$25 PCP /$40 SPC	
WELL CARE	$25 PCP /$40 SPC		$25 PCP /$40 SPC		$25 PCP /$40 SPC	
URGENT CARE	$50		$50		$50	
PRESCRIPTIONS	RETAIL	MAIL-ORDER	RETAIL	MAIL-ORDER	RETAIL	MAIL-ORDER
TIER 1	$10	$20	$10	$20	$10	$20
TIER 2	$25	$65	$25	$65	$25	$65
TIER 3	$40	$100	$40	$100	$40	$100
EMERGENCY ROOM	$100		$100		$150 + 30%	
HOSPITAL SERVICES	DEDUCTIBLE + 20%		DEDUCTIBLE + 20%		DEDUCTIBLE + 30%	
ANNUAL DEDUCTIBLE						
PER PERSON	$500		$1,000		$1,500	
PER FAMILY	$1,500		$3,000		$4,500	
ANNUAL OUT OF POCKET MAXIMUM						
PER PERSON	$1,500		$2,500		$4,000	
PER FAMILY	$3,000		$5,000		$8,000	
EMPLOYEE WEEKLY RATES						
SINGLE	$40.16		$33.93		$30.19	
EMPLOYEE/SPOUSE	$92.05		$79.58		$72.10	
EMPLOYEE/CHILD(REN)	$86.32		$74.47		$67.37	
FAMILY	$159.72		$139.77		$127.81	

1. DEDUCTIBLE(S) DO NOT APPLY TO PRESCRIPTION MEDICATION, SERVICES RECEIVED AT THE DOCTOR'S OFFICE (EXCEPT ALLERGY TESTING), AT AN URGENT CARE CENTER OR HOSPITAL EMERGENCY ROOM
2. THE OUT OF POCKET MAXIMUM INCLUDES THE DEDUCTIBLE.
3. FLAT DOLLAR COPAYS ARE EXCLUDED FROM THE OUT OF POCKET MAXIMUM
4. SEE SUMMARY OF BENEFITS FOR OUT OF NETWORK BENEFITS
5. GRID IS FOR COMPARATIVE PURPOSES ONLY. PLEASE REFER TO THE CERTIFICATE OF COVERAGE FOR COMPLETE DETAILS.
6. ALL HEALTH BENEFIT PLANS HAVE LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO THE CERTIFICATE OF COVERAGE FOR COMPLETE DETAILS.
7. PRESCRIPTIONS AVAILABLE AND ORDERED THROUGH ANTHEM'S MAIL ORDER PROGRAM PROVIDING A 90 DAY SUUPLY.

8. **ALL PLANS PROVIDE COVERAGE FOR THE EXACT SAME TYPES OF MEDICAL SERVICES AND MEDICATIONS. THE DIFFERENCE IN THE PLANS IS HOW THE COST OF SERVICES ARE SHARED BY YOU AND ANTHEM BCBS AND THE PREMIUM AMOUNT YOU PAY FOR EACH PLAN.**

PREPARED 12/18/2006

SUMMITT TRUCKING
2007 HEALTH PLAN COVERAGES AND COSTS

PREPARED 12/18/2006