### BENEFITS

<table>
<thead>
<tr>
<th>Coverage Type Selected</th>
<th>PLAN A PPO Medical with Indemnity Dental and Vision and Audio</th>
<th>PLAN B PPO Medical with Indemnity Dental and Vision and Audio</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month employees</td>
<td>$86.94 $115.92 $146.36 $195.15</td>
<td>$235.46 $313.95 $373.30 $497.74</td>
</tr>
<tr>
<td>9-month employees</td>
<td>$86.94 $115.92 $146.36 $195.15</td>
<td>$235.46 $313.95 $373.30 $497.74</td>
</tr>
</tbody>
</table>

**MEDICAL WITH PRESCRIPTION DRUGS**

**Type of Plan**

- Preferred Provider Organization Plan (PPO)

**National network of physicians, hospitals, and ancillary services**

- Private HealthCare Systems available nationwide [www.phcs.com](http://www.phcs.com)

**Lifetime Maximum Benefit**

- $1,000,000 per person
- Unlimited per person

**Primary Care Physician (PCP) referral required**

- NO – in or out of network
- NO – in or out of network

**In-network deductible per yr/person**

- Plan A: $500 individual / $1,500 family
- Plan B: $0 individual / $0 family

**Out-network deductible per year**

- Plan A: $1,000 individual / $3,000 family
- Plan B: $500 individual / $1,500 family

**In-network co-insurance**

- 80% paid by plan after deductible with maximum out of pocket expense per person per year of $3,000 ($9,000 per family) not including deductible
- 80% paid by plan with maximum out of pocket expense per person per year of $2,000 ($6,000 per family); no deductible applies

**Out-network co-insurance after satisfaction of calendar year deductible**

- 50% with maximum out of pocket expense per person per year of $7,500 per person ($22,500 per family) including deductible
- 50% with maximum out-of-pocket expense per person per year of $5,000 per person ($15,000 per family) not including deductible

**In-network physician office visits and related diagnostic x-ray and laboratory expenses**

- $35 co-payment for each primary or specialist visit with balance paid at 100%
- $30 co-payment for each primary or specialist visit with balance paid at 100%

**Important:** Co-pays are reduced by $10 for all visits to any Morehouse Medical Associates location

**Out-network physician office visits**

- Plan pays 50% after satisfaction of deductible
- Plan pays 80% after satisfaction of deductible

**In-network hospital charges (in- or out-patient)**

- Plan pays 80% after satisfaction of deductible
- Plan pays 80% (deductible does not apply)

**In-network surgery and related expenses (in- or out-patient)**

- Plan pays 80% after satisfaction of deductible
- Plan pays 80% (deductible does not apply)

**Out-network surgery and related expenses (in- or out-patient)**

- Plan pays 50% after satisfaction of deductible
- Plan pays 50% after satisfaction of deductible

**Wellness and Routine Care (adult and child)**

- Payable as any other illness (no annual or lifetime maximum benefit or restrictions)
- Payable as any other illness (no annual lifetime maximum benefit or restrictions)

**Emergency Room**

- $250 co-payment per visit to in- or out-network facility (waived if admitted)
- $250 co-payment per visit to in or out-network facility (waived if admitted)

**Chiropractic Treatment**

- Plan pays 80% in-network or 50% out of network (after satisfaction of the deductible) subject to maximum of 52 visits per year
- Plan pays 80% in-network or 50% out of network (after satisfaction of the deductible) subject to maximum of 52 visits per year

**Acupuncture Treatment**

- Plan pays 80% in-network or 50% out of network (after satisfaction of the deductible) subject to maximum of 52 visits per year
- Plan pays 80% in-network or 50% out of network (after satisfaction of the deductible) subject to maximum of 52 visits per year

**Prescription Drugs**

- $15 approved generic / $30 approved brand / $60 non-approved. 90-day supply available for ONE MONTHLY CO-PAYMENT through mail order program (forms available from Human Resources or by calling 1-800-854-8764 or via internet [www.drugsourceinc.com](http://www.drugsourceinc.com))

**Diabetes Education**

- Plan pays 100% of the annual cost of physician prescribed Diabetes classes.

### DENTAL INSURANCE

**Plan Type**

- Indemnity – passive list of providers through [www.connectiondental.com](http://www.connectiondental.com)

**Deductible per cal. year**

- $50 per person/$150 per family (waived Preventive Services)

**Co-insurance (% Plan pays)**

- 100% preventive; 80% basic; 50% major; 50% orthodontia subject to reasonable and customary fee guidelines. Connection Dental will discount their fees and accept the adjustment to “reasonable and customary.”

**Orthodontia maximum**

- $2,000 per lifetime (adult and child)

**Dental maximum**

- $2,000 per person per calendar year

### VISION INSURANCE

**Plan Type**

- Indemnity – no list of providers – freedom of choice. PHCS provider may be used who will charge only the office visit co-pay for the exam and who will file the claim with Group Resources.

**Deductible per person**

- None

**Benefit per person per year**

- Annual (per calendar year) allowance of $400 per person

### AUDIO INSURANCE

**Plan Type**

- Indemnity – no list of providers – freedom of choice. Reduced fees will, however, be charged by an in-network PHCS provider who will also file the claim with Group Resources.

**Hearing correction**

- A benefit equal to $300 (no co-payment, no deductible) is payable once each five-year period for all services (including exam and hearing aid) related to routine hearing correction. Note, treatment/surgery for hearing loss as a result of disease or injury is payable under the “Medical” portion of the Plan.

### MONTHLY PRE-TAX PAYROLL DEDUCTIONS PER EMPLOYEE (MEDICAL/PRESCRIPTIONS/DENTAL/AUDIO/VISION)

**Coverage Type Selected**

<table>
<thead>
<tr>
<th>Employee Only</th>
<th>Employee with Child(ren)</th>
<th>Employee with Spouse</th>
<th>Employee with Family</th>
</tr>
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