CLARK ATLANTA UNIVERSITY

PLANS OF MEDICAL/PRESCRIPTION DRUGS WITH DENTAL, VISION AND AUDIO *REVISED EFFECTIVE 1/1/2012*

BENEFITS	PLAN A Medical/Rx/Dental/Vision/Audio	PLAN B Medical/Rx/Dental/Vision/Audio
Claims processed by Group Resources	Contact dedicated claim processor – Debbie Deyton at 770/623-8383 (ddeyton@groupresources.com)	
MEDICAL WITH PRESCRIPTION DRUGS		
Type of Plan	Preferred Provider Organization Plan (PPO)	
National network of physicians, hospitals, and ancillary services	Multi-Plan/Private HealthCare Systems available nationwide www.multiplan.com	
Annual maximum	$1,250,000 per person	Unlimited
Primary Care Physician referral required	NO – in or out of network	NO – in or out of network
In-network deductible per yr/person	$500 individual / $1,500 family	$0 individual / $0 family
Out-network deductible per year	$1,000 individual / $3,000 family	$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) not 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 50% 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)
In-Network Diagnostic Lab & X-Ray Quest Lab Card One Call Medical (MRI/CT/PET Scan)	Plan pays 80% after satisfaction of deductible Plan pays 100% (deductible does not apply) Plan pays 100% (deductible does not apply)	Plan pays 80% (deductible does not apply) Plan pays 100% (deductible does not apply) Plan pays 100% (deductible does not apply)
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 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 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
CVS/Minute Clinic	$15 co-payment for each visit with balance paid at 100%	$10 co-payment for each visit with balance paid at 100%
TelaDoc Telephone Consultation (Covered employees, dependent spouses, and dependent children call 800-TELADOC)	$0 co-payment for each consultation with balance paid at 100%	$0 co-payment for each consultation with balance paid at 100%
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 OR a 90-day supply may now be purchased for ONE MONTHLY CO-PAYMENT at any retail store that is a participating Script Care pharmacy. A Diabetes Management Program is included along with a Specialty Drug Program.	
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	
Deductible per cal. Year	$50 per person/$150 per family (waived Preventive Services)	
Coinsurance (% 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 (The calendar year maximum does not apply to dependents under age 19.)	
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 (The calendar year maximum does not apply to dependents under age 19.)	
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 $400 (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/VISION/AUDIO)

Coverage Type Selected	Plan A		Plan B	
	12 month employees	9 month employees	12 month employees	9 month employees
Employee only	$ 95.85	$127.81	$161.36	$215.15
Employee with Child(ren)	$141.77	$189.03	$232.08	$309.44
Employee with Spouse	$169.74	$226.32	$277.40	$369.87
Employee with Family	$259.59	$346.12	$411.57	$548.76