CLARK ATLANTA UNIVERSITY

PLANS OF MEDICAL/PRESCRIPTION DRUGS WITH DENTAL, VISION AND AUDIO

BENEFIT REVISIONS EFFECTIVE 1/1/07 HIGHLIGHTED

BENEFITS	PLAN A PPO Medical with Indemnity Dental and Vision and Audio	PLAN B PPO Medical with Indemnity Dental and Vision and Audio
All Claims processed by	Group Resources – Duluth, Georgia; Contact dedicated claim processor – Malana Stowers at 770/623-8383 (malana@groupresources.com)	
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	
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	$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)
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)
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.	
DENTAL INSURANCE – no changes effective 1/1/07		
Plan Type	Indemnity – passive list of providers through 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 – no changes effective 1/1/07		
Plan Type	Indemnity – no list of providers – freedom of choice	
Deductible per person	None	
Benefit per person per year	$60 annual eye exam; $100 pair lenses (including contacts) per year; $200 frames per year	
AUDIO INSURANCE – no changes effective 1/1/07		
Plan Type	Indemnity – no list of providers – freedom of choice. Reduced fees will, however, be charged by an in-network PHCS provider.	
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)
No change in deductions effective January 1, 2007 through December 31, 2007

Coverage Type Selected	Plan A Option		Plan B Option	
	12 month employees	9 month employees	12 month employees	9 month employees
Employee only	$ 75.60	$100.80	$127.27	$170.17
Employee with Child(ren)	$111.82	$149.10	$183.04	$244.53
Employee with Spouse	$133.88	$178.50	$218.79	$291.72
Employee with Family	$204.75	$273.00	$324.61	$433.29