




# 2009 Benefits Summary Guide

## EAP, ACCIDENT, AND LIFE (Company Paid)

CATEGORY	Employee Assistance (EAP) / Work-Life Program 	Accident Reimbursement Arrangement (ARA) 	Life Insurance/ Accidental Death & Dismemberment (AD&D) 
Who pays for this benefit for me?	Your company pays the entire cost.	Your company pays the entire cost for the employee.	Your company pays the entire cost for basic coverage (\$20,000 of life and an additional \$20,000 of AD&D unless your employer chooses a different amount). If you want Additional Life coverage, you can elect and pay for it on an after-tax basis (subject to underwriting).
Who pays for this benefit for my dependents?	All your household members, and children at college, are covered as part of this benefit provided by your company.	Not available for dependents at this time.	If you choose Additional Life for your spouse or children, you will pay the entire cost on an after-tax basis.
Who is covered for this benefit?	All full-time employees, all household members and children in college.	All full-time and part-time employees.	All full-time employees. Additional Life for employees and dependents must be applied for, approved by MetLife and paid for by you.
What does the benefit basically cover?	3 local, in-person, counseling visits per issue per year. Free 30 minute expert consultation with a licensed legal or financial professional. Over 50 on-line career and work-life training courses. Free health risk appraisal/health coaching & \$10 gift certificate (1/yr).	Reimbursed up to \$1,000 per covered accident to a maximum of 5,000 per employee per calendar year. Deductibles and co-pays not required. 100% coverage/80% for Rx, no network. Easy to use and file with claims payer. NOT tied to medical plan participation.	\$20,000 of employee basic life. \$20,000 of employee AD&D. Opportunity to purchase Additional Life on employee. Opportunity to purchase Additional Life on spouse and/or children. See information below on how to apply for Additional Life.
Where do I find more information?	Go to <a href="http://www.employersresource.com">www.employersresource.com</a> . Click on Employee Service Center, then Additional Employee Benefits. Call the Employers Resource Benefits Department at 866-214-9506.		

## VISION (Employee Paid Less Any Applicable Company Contribution)



### YOUR COPAYS/COVERAGE

Exam..... \$10  
 Prescription Glasses..... \$25  
 Contacts..... No copay applies  
**Exam Covered in Full.....**every calendar year  
**Prescription Glasses**  
 Lenses covered in full every calendar year  
 Single vision, lined bifocal and lined trifocal lenses  
 Polycarbonate lenses for children  
 Frames..... every other calendar year  
 Frame of your choice covered up to \$120  
 Plus, 20% off any out-of-pocket costs  
 ~OR~  
**Contact Lens Care.....**every calendar year  
 When you choose contacts instead of glasses, your \$120 allowance applies to the cost of your contacts and contact lens exam (fitting/evaluation). This exam is in addition to your vision exam for proper contact fitting.

### EXTRA DISCOUNTS AND SAVINGS

#### Laser Vision Correction Discounts

#### Prescription Glasses

Up to 20% savings on lens extras such as coatings and progressives  
 20% off additional prescription glasses and sunglasses

#### Contacts

15% off cost of contact lens exam (fitting and evaluation)  
 Available from same VSP doctor who provided your exam within last 12 months



### OUT-OF-NETWORK BENEFITS

Dollar for dollar, you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement if you decide to see an out of network provider.

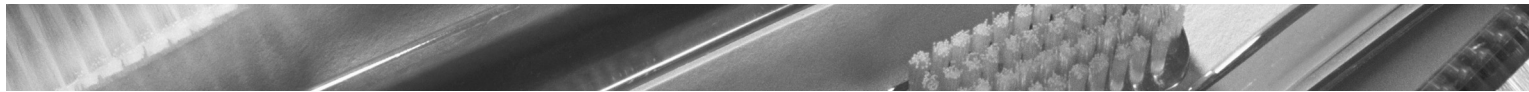
#### Out-of-Network Reimbursement Amounts:

**Exam.....** Up to \$45  
**Lenses:**  
 Single Vision ..... Up to \$45  
 Lined Bifocal ..... Up to \$65  
 Lined Trifocal ..... Up to \$85  
 Frame ..... Up to \$47  
 Contacts ..... Up to \$105

[vsp.com](http://vsp.com) 800-877-7195

Monthly Cost	Employee: \$10.00	Empl. + Spouse: \$18.00	Empl. + Children: \$18.00	Family: \$25.00
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# **DENTAL-TX** (Employee Paid Less Any Applicable Company Contribution)



## PLAN DESIGN SUMMARY

Plan Design Elements	Traditional Preferred In & Out of Network <sup>4</sup>	Preventive Plus In & Out of Network <sup>4</sup>	SafeGuard DHMO <sup>5</sup> In Network Only
Deductible <sup>1</sup>			
Individual	\$50.00	\$50.00	None
Family	\$150.00	\$150.00	None
Preventive Services	100% (no deductible)	100% (no deductible)	\$0 - \$50
Basic Services	80% (after deductible)	50% (after deductible)	\$10 - \$200
Major Services	50% (after deductible)	Discount Services	\$30 - \$380
Annual Benefit Max	\$1,500.00	\$1,000.00	N/A
Orthodontic Services	50% <sup>2</sup>	Discount Services	Adult & Child - \$1,695
Orthodontic Deductible	N/A	N/A	N/A
Ortho Lifetime Max	\$1,000.00	N/A	24 months of treatment
Waiting Periods <sup>3</sup>	YES	YES	NO
Must Stay in Network	NO	NO	YES
Need a Primary Dentist	NO	NO	YES
Employee	\$30.92	\$10.84	\$12.59
Employee & Spouse	\$71.49	\$23.76	\$23.92
Employee & Child(ren)	\$61.36	\$26.84	\$25.18
Family	\$102.17	\$41.82	\$39.03

1. Calendar year deductible applies to Basic and Major services ONLY. Deductible is waived on preventative services.

2. Child orthodontia ONLY available up to age 19 on Traditional Preferred plan.

3. Waiting periods apply to major & orthodontia services without proof of 12 months of prior coverage.

4. Humana pays out-of-network dentists generally at the 90th percentile of Usual, Customary and Reasonable (UCR). You may be balanced billed for amounts charged above that by non-contracted dentists.

5. A \$5 office visit copay applies when using the SafeGuard DHMO Plan.

**HUMANA**  
Guidance when you need it most

When paying In-Network claims, Humana has negotiated rates with each dentist that they can charge for certain procedures.

When paying Out-of-Network claims, Humana has certain charges that are deemed fair for a dentist to bill for a certain procedure. It is approximately 90% of the average procedure cost or what is called Usual, Customary and Reasonable (UCR).

Website: [www.humanadental.com](http://www.humanadental.com) (all three plans)

Phone: Humana: 800-233-4013/Group #679563

Phone: Safeguard DHMO: (800-388-3910)

## SAMPLE PROCEDURES/REIMBURSEMENTS

Sample Procedure (Average Cost) <sup>1</sup>	Payment from Plan: Traditional Preferred In & Out of Network	Payment from Plan: Preventive Plus In & Out of Network	Payment: SafeGuard DHMO In Network Only \$5/Visit + Copays Below
Cleaning (\$68)	100%	100%	\$0 Copay, then 100%
Bite Wing X-Rays (\$31 - 2 Ims, \$40 - 4 Ims)	100%	100%	\$0 Copay, then 100%
Amalgam Filling (\$95 - 1 surface)	80% after deductible	50% after deductible	\$10 Copay, then 100%
Basic Extraction (\$91)	80% after deductible	50% after deductible	\$5-\$30 Copay, then 100%
Perio Scaling/Root Planning (\$175 for 1-3 teeth)	80% after deductible	Discount	\$30 Copay, then 100%
Root Canal (\$825)	80% after deductible	Discount	\$80-\$200 Copay, then 100%
Porcelain Crown (\$930)	50% after deductible	Discount	\$185 Copay, then 100%
Orthodontia	50% up to \$1000 max	Discount	\$1,695 Copay, then 100%
Complete Denture - Upper (\$1,050)	50% after deductible	Discount	\$210 Copay, then 100%

1. The costs listed are average costs and will vary based on your region.

These are examples only. Each dentist has different rates and they may charge prices very different from those listed.

### EXAMPLE:

Amalgam Filling (1 Surface)

*Assumes calendar year deductible has been met*

Humana In-Network dentist charge: \$122

Out-of-Network dentist charge: \$170 (plan allows \$152 for UCR)

Traditional Preferred		Preventive Plus		DHMO
In-Network	Out of Network	In-Network	Out of Network	Out of Network
\$122 x 80%	\$152 x 80%	\$122 x 50%	\$152 x 50%	\$5 Office Copay + \$10 Copay, then %100
Plan Pays: \$97.60	Plan Pays: \$121.60	Plan Pays: \$61.00	Plan Pays: \$76.00	
You Pay: \$24.40	You Pay: \$48.40	You Pay: \$61.00	You Pay: \$94.00	
	\$30.40 of \$152 balance + <u>\$18.00</u> over UCR \$48.40		\$76.00 of \$152 balance + <u>\$18.00</u> over UCR \$94.00	

