



Employee Benefit At-A-Glance 2009

Travelers

Quality People  
Quality Patient Care

|   |            | BLUE CROSS BLUE SHIELD OF GEORGIA  |  |  |  |  |
|---|------------|--|--|--|--|--|
|   |            | Referral Required  | Open Access  |  |  |  |
|   |            | HMO 6001 SX  | HMO 6004 AX  | PPO 410  | PPO 4201 SX  | PPO 4501 SX  |
| <b>Medical</b>  |            |  |  |  |  |  |
| <b>Co-Insurance</b>   |            | 100%   | 100%   | 80% / 60%  | 90% / 60%  | 80% / 60%  |
| <b>Calendar Year Deductible</b>                             |            |  |  |  |  |  |
| In-Network:   | Individual | \$500  | N/A  | \$300  | \$500  | \$1,000  |
|   | Family     | \$1,500  | N/A  | \$900  | \$1,500  | \$3,000  |
| Out-of-Network:   | Individual | N/A  | N/A  | \$300  | \$1,000  | \$2,000  |
|   | Family     | N/A  | N/A  | \$900  | \$3,000  | \$6,000  |
| <b>Out-of-Pocket Maximum</b><br>(After meeting deductible)  |            |  |  |  |  |  |
| In-Network:   | Individual | None   | None   | \$2,000  | \$1,000  | \$1,000  |
|   | Family     | None   | None   | \$6,000  | \$3,000  | \$3,000  |
| Out-of-Network:   | Individual | N/A  | N/A  | \$4,000  | \$4,000  | \$2,000  |
|   | Family     | N/A  | N/A  | \$12,000   | \$12,000   | \$6,000  |
| <b>Office Visit Copay</b>                                   |            |  |  |  |  |  |
| In-Network:   |            | \$25 PCP / \$35 Specialist   | \$25 PCP / \$35 Specialist   | \$10 PCP / \$20 Specialist   | \$25 PCP / \$25 Specialist   | \$40 PCP / \$40 Specialist   |
| Out-of-Network:   |            | N/A  | N/A  | 60%; after deductible  | 60%; after deductible  | 60%; after deductible  |
| <b>Hospital / Inpatient Services</b>                        |            |  |  |  |  |  |
| In-Network:   |            | 100%; after deductible   | 100%   | 80%; after deductible  | 90%; after deductible  | 80%; after deductible  |
| Out-of-Network:   |            | N/A  | N/A  | 60%; after deductible  | 60%; after deductible  | 60%; after deductible  |
| <b>Outpatient Services</b>                                  |            |  |  |  |  |  |
| In-Network:   |            | 100%; after \$100 Copay  | 100%; after \$100 Copay  | 80%; after deductible  | 90%; after deductible  | 80%; after deductible  |
| Out-of-Network:   |            | 100%; after \$100 Copay  | N/A  | 60%; after deductible  | 60%; after deductible  | 60%; after deductible  |
| <b>Emergency Room Services</b>                              |            |  |  |  |  |  |
| In-Network:   |            | \$100 Copay  | \$100 Copay  | \$100 Copay  | \$100 Copay  | \$100 Copay  |
| Out-of-Network:   |            | N/A  | N/A  | \$100 Copay  | \$100 Copay  | \$100 Copay  |
| <b>Medical Lifetime Max. Benefits</b>                       |            | Unlimited  | Unlimited  | \$2,000,000  | \$5,000,000  | \$5,000,000  |
| <b>Prescription Coverage</b>                                |            | <ul style="list-style-type: none"> <li>• Generic - \$15 Copay</li> <li>• Brand - \$30 Copay</li> <li>• Non-Formulary - \$60 Copay</li> </ul> | <ul style="list-style-type: none"> <li>• Generic - \$15 Copay</li> <li>• Brand - \$30 Copay</li> <li>• Non-Formulary - \$60 Copay</li> </ul> | <ul style="list-style-type: none"> <li>• Generic - \$15 Copay</li> <li>• Brand - \$30 Copay</li> <li>• Non-Formulary - \$60 Copay</li> </ul> | <ul style="list-style-type: none"> <li>• Generic - \$15 Copay</li> <li>• Brand - \$30 Copay</li> <li>• Non-Formulary - \$60 Copay</li> </ul> | <ul style="list-style-type: none"> <li>• Generic - \$15 Copay</li> <li>• Brand - \$30 Copay</li> <li>• Non-Formulary - \$60 Copay</li> </ul> |
| <b>Mail Order Maintenance Only</b><br>(Up to 90 day supply) |            | \$60 Copay (Brand & Generic)   | \$60 Copay (Brand & Generic)   | Not Covered  | \$60 Copay (Brand & Generic)   | \$60 Copay (Brand & Generic)   |

**Contacts & Plan Information**

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Medical - **BCBS**  
**Member Services**  
(800) 441-2273  
[www.bcbsga.com](http://www.bcbsga.com)

Limited Medical -  
**Cigna/Starbridge**  
**Member Services**  
(800) 308-5948  
[www.starbridgeselect.com](http://www.starbridgeselect.com)

Dental - **MetLife**  
**Member Services**  
(800) ASK-4-MET  
[www.metlife.com](http://www.metlife.com)

Vision - **Vision Service Plan**  
**Member Services**  
(800) 877-7195  
[www.vsp.com](http://www.vsp.com)

Life/Disability - **Unum**  
**Member Services**  
(800) 633-7479  
[www.unum.com](http://www.unum.com)

Please Note: This document is intended as a convenient summary of the major points of benefit plans. This booklet does not cover all provisions, limitations and exclusions. The official plan documents, policies and certificates of insurance govern in all cases and are available for your inspection at any time.

**Dental**

**Deductible** \$50 - Individual  
\$150 - Family

**Annual Plan Maximum** \$1,500  
100% Deductible Waived

**Preventative Services**  
Routine exams, cleanings, bitewing x-rays, Fluoride treatment, Sealants, etc.

**Basic Services** 80%  
Fillings, Simple oral surgery, Full mouth x-rays, Simple Surgery, Periodontics, etc.

**Major Services** 50%  
Crowns, Inlays & Onlays, Bridges, Dentures, Root canal, etc.

•Network Provider Reimbursement Based on Reeducated Contracted Fees  
•Non-Network Provider Paid at 90% Percentile Usual & Customary

**Limited Medical**

Applicable to Consultants who are not insured for medical benefits and do not require major medical coverage.

**Doctor Office Visits:**  
\$10 Copay; Plan Max. \$1,500 Year  
(Accumulates \$1,500 Out-Patient benefit)

**Outpatient Services:**  
\$100 Deductible; 80% Reimbursement;  
Plan pays up to \$1,500/Year

**Wellness/Routine Services:**  
\$20 Copay; Maximum 1 service per year;  
Plan pays \$100 per year

**Inpatient Services:**  
100% Reimbursement; Plan pays up to \$1,500 per occur.  
Maximum 2 occurrence/year (\$3,000)/yr.

**Accident:**  
\$50 per occurrence deductible;  
Maximum 2 occurrences/year  
Plan pays 80% to \$2,500 per occurrence

**Prescription:**  
• Generic - \$15 Copay  
• Brand - \$30 Copay  
Plan pays Maximum of \$300/yr.

**Vision**

|                                       | In-Network   | Out-of-Network Reimbursement                       |
|---------------------------------------|--|--|
| <b>Frequency</b> (exam/lenses/frames) | 1 X 12 Month Exam & Lenses<br>1 X 24 Months Frames | 1 X 12 Month Exam & Lenses<br>1 X 24 Months Frames |
| <b>Exam</b>                           | Covered in full after \$10 copay                   | Up to \$46   |
| <b>Single Vision</b>                  | Covered in full after \$25 copay                   | Up to \$55   |
| <b>Bifocal</b>                        | Covered in full after \$25 copay                   | Up to \$75   |
| <b>Trifocal</b>                       | Covered in full after \$25 copay                   | Up to \$95   |
| <b>Contacts:</b>                      |  |  |
| • Conventional / Disposables          | \$105 Allowance                                    | \$105 Allowance                                    |
| • Medically Necessary                 | Covered in full                                    | \$210 Allowance                                    |
| <b>Frames</b> (retail allowance)      | \$120 Allowance                                    | Up to \$45   |

**Contributions**

|                       | CIGNA       |             |          |             |             |                        | Dental  | Vision | Voluntary Life / Short Term Disability |
|-----------------------|-------------|-------------|----------|-------------|-------------|------------------------|---------|--------|--|
|                       | HMO 6001 SX | HMO 6004 AX | PPO 410  | PPO 4201 SX | PPO 4501 SX | Starbridge Limited Med |         |        |  |
| <b>Weekly</b>         |             |             |          |             |             |                        |         |        |  |
| Employee              | \$23.85     | \$25.58     | \$40.52  | \$35.99     | \$28.85     | \$0.00                 | \$6.39  | \$1.68 | Deductions are                         |
| Employee + Spouse     | \$70.89     | \$77.19     | \$114.51 | \$106.32    | \$90.87     | \$30.13                | \$12.38 | \$3.20 | based on employ-                       |
| Employee + Child(ren) | \$66.35     | \$72.21     | \$107.11 | \$99.45     | \$85.00     | \$30.13                | \$12.38 | \$3.35 | ee's age and                           |
| Family                | \$123.00    | \$134.37    | \$199.33 | \$185.09    | \$158.19    | \$55.64                | \$17.95 | \$5.15 | benefit election                       |

**Voluntary Life Insurance**

**Employee Coverage**  
Up to 5 times salary in increments of \$10,000 not to exceed \$500,000; Guaranteed \$100,000 if enroll @ Date of Hire

**Spouse Coverage**  
100% of employee's amount in increments of \$5,000 not to exceed \$500,000; Guaranteed \$25,000 if enroll @ Date of Hire

**Dependent Coverage**  
In increments of \$2,000 not to exceed \$10,000; if enroll @ Date of Hire

**Voluntary Short Term Disability**

**Weekly Benefit** 50%  
**Maximum Weekly Benefit** \$1,000  
**Benefit Waiting Period** 14 days  
**Maximum Benefit Period** 11 Weeks  
100% Employee Paid

**Long Term Disability**

**100% Employer Paid** 40% Earnings  
**Maximum Monthly Benefit** \$2,000  
**Employee Buy Up Option** 60% Earnings  
**Maximum Monthly Benefit** \$4,000  
**Benefit Waiting Period** 90 Days  
**Maximum Benefit Period** Age 65

**Basic Life & AD&D**  
**100% Employer Paid**  
**Life - \$10,000**  
**AD&D - \$10,000**

**EAP -**

**Employee Assistance Program**  
• Personal • Legal  
• Financial Assistance  
Toll Free # (800)854-1446  
[www.lifebalance.net](http://www.lifebalance.net)  
ID & Password: Life Balance

**Detail Information & Enrollment Log On:**  
[www.mdmedicalplans.com](http://www.mdmedicalplans.com)  
Company Code Login: mdiconsultants