# 2007-2008 Medical Plan Designs

| Aetna, Inc. | | | | | | |
|---|---|---|---|---|---|---|
| Product Type | Plan 1** | | Plan 2** | | H.S.A | |
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| | | | | | | |
| Maximum | $5,000,000 | | $5,000,000 | | $5,000,000 | |
| Wellness | $25 Co-Pay then Covered at 100% | | $25 Co-Pay then Covered at 100% | | Covered at 100% | Covered at 20% |
| Physicians Office Visit Co-Pay | $25 Co-Pay | 50% | $25 Co-Pay | 50% | Deductible Only | 20% |
| Specialist Office Visit Co-Pay | $50 Co-Pay | 50% | $50 Co-Pay | 50% | Deductible Only | 20% |
| Calendar Year Deductible | $500/2x Family | $1,000/2x Family | $1,500/2x Family | $3,000/2x Family | $2,500/2x Family | $2,500/2x Family |
| Coinsurance Limit | $3,000/2x Family | $7,000/2x Family | $4,500/2x Family | $9,000/2x Family | $5,000/2x Family | $10,000/2x Family |
| Hospital In-Patient Charges | $250 Co-Pay then 20% | $500 Co-Pay then 50% | $250 Co-Pay then 20% | $500 Co-Pay then 50% | Deductible Only | 20% |
| Out-Patient Facility | 20% | 50% | 20% | 50% | Deductible Only | 20% |
| Urgent Care Facility | $75 Co-Pay | 50% | $75 Co-Pay | 50% | Deductible Only | 20% |
| Emergency Room Facility | $150 Co-Pay | | $150 Co-Pay | | Deductible Only | |
| Emergency Room Charges | Included in Facility Charges | | Included in Facility Charges | | Deductible Only | |
| Prescription Benefit | $5/$25/$40 | | $5/$25/$40 | | $10/$15/$30 after Medical Deductible | |
| Mail Order | Two Co-Pay for 3 Months | | Two Co-Pay for 3 Months | | Two Co-Pay for 3 Months after Med. Deductible | |
| Network | Choice POS 2 | | Choice POS 2 | | Choice POS 2 | |
| Monthly Rates | **Employer Portion** | **Employee Portion** | **Employer Portion** | **Employee Portion** | **Employer Portion** | **Employee Portion** |
| Employee Only | $441.35 | $106.26 | $398.98 | $52.50 | $302.38 | $35.00 |
| Employee + Child(ren) | $882.70 | $250.26 | $797.96 | $110.50 | $633.24 | $75.00 |
| Employee + Spouse | $907.70 | $275.26 | $812.96 | $125.50 | $784.43 | $90.00 |
| Employee + Family | $1,238.35 | $306.26 | $1,060.90 | $145.00 | $1,209.53 | $100.00 |

**Notes for Plan 1 & Plan 2:
Office Visit Co-Pays are applied toward Coinsurance not Deductible
Current Deductibles met through May 31, 2007 will transfer to new plan.
Deductible is not needed where Co-Pays are applied.

# 2007-2008 Dental & Vision Plan Designs

| Aetna, Inc. | | |
|---|---|---|
| Product Type - Dental | PDN/PPO | DMO** |
| **DMO not available in all areas | | |
| Yearly Maximum | $1,500 | Unlimited |
| CYD~Individual/Family | $50/$150 | $0/$0 |
| Office Visit Co-Pay | N/A | $5 |
| | | |
| Preventative | 100% | 100% |
| Basic | 80% | 80% |
| Major | 50% | 50% |
| On PPO there is a 12 month wating period for Major Services. | | |
| Ortho | 50% | $2,400 Co-Pay |
| Ortho~Lifetime Max | $1,000 | Unlimited |
| Ortho~Eligible | Child Only | Adult & Child |
| Network | Aetna Dental PDN/PPO | Aetna DMO |
| **Monthly Dental Rates** | | |
| Employee Only | $22.50 | |
| Employee + Child(ren) | $53.06 | |
| Employee + Spouse | $47.22 | |
| Employee + Family | $77.80 | |

| Avesis, Inc. | |
|---|---|
| Product Type - Vision | Plus Plan |
| | Avesis Network |
| Eye Exam | Covered in Full |
| Frame | $100-$150 Allowance |
| Exam, Lenses, Frames, & Contact Lenses Every 12 Months | |
| | |
| Contact Lenses | |
| Elective | $130 Allowance |
| Medically Necessary | Covered in Full |
| | |
| Spectacle Lenses | |
| Standard Single Vision | Covered in Full |
| Standard Bifocal | Covered in Full |
| Standard Trifocal | Covered in Full |
| Standard Lenticular | Covered in Full |
| | |
| Co-Pay | |
| Vision Examination | $10.00 |
| Materials | $10.00 |
| **Monthly Vision Rates** | |
| Employee Only | $7.34 |
| Employee + Child(ren) | $15.42 |
| Employee + Spouse | $12.85 |
| Employee + Family | $19.09 |

Diversified Employee Benefit Services, Inc.
Stephen G. Geri, MGA
sgeri@dibsinsurance.com
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# 2007-2008 Supplemental life Rates

Example Monthly Charges:

| Age Bands | Rate | $25,000 | $50,000 | $75,000 | $100,000 |
|---|---|---|---|---|---|
| Under 30 | $0.120/$1,000 | $3.00 | $6.00 | $9.00 | $12.00 |
| 30-34 | $0.120/$1,000 | $3.00 | $6.00 | $9.00 | $12.00 |
| 35-39 | $0.150/$1,000 | $3.75 | $7.50 | $11.25 | $15.00 |
| 40-44 | $0.220/$1,000 | $5.50 | $11.00 | $16.50 | $22.00 |
| 45-49 | $0.300/$1,000 | $7.50 | $15.00 | $22.50 | $30.00 |
| 50-54 | $0.510/$1,000 | $12.75 | $25.50 | $38.25 | $51.00 |
| 55-59 | $0.880/$1,000 | $22.00 | $44.00 | $66.00 | $88.00 |
| 60-64 | $1.070/$1,000 | $26.75 | $53.50 | $80.25 | $107.00 |
| 65-69 | $1.540/$1,000 | $38.50 | $77.00 | $115.50 | $154.00 |
| 70-74 | $2.460/$1,000 | $61.25 | $123.00 | $184.50 | $246.00 |
| Over 74 | $3.950/$1,000 | $98.75 | $197.50 | $296.25 | $395.00 |

# 2007-2008 Disability & Life Plan Designs
## 100% Employer Paid Benefit

| **Aetna, Inc.** |
| --- |
| Product Type - Disability |
| Short-Term (Hourly Only) |
| 60% of Weekly Wage/Max Benefit $1,000<br>Begins: 8 Days Accident/8 Days Sickness/1 Day Surgery<br>Max Period 13 Weeks |
| Long-Term |
| 60% of Monthly Salary<br>Max Benefit $10,000<br>90 Day Waiting Period<br>Payable to Age 65 |

| **Aetna, Inc.** |
| --- |
| Product Type - Group Life and AD&D |
| $100,000 For All Employees |
| Supplemental Life Option Available |

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**I. Employee Information (PLEASE PRINT AND COMPLETE ALL INFORMATION)**

| Social Security | Last Name | First Name | Middle Initial | To be completed by Employer Only | |
|---|---|---|---|---|---|
| | | | | Group # | Location # |
| Street Address | City | State | Zip Code | Hourly ☐<br>Salary ☐ | Annual Earnings |
| | | | | | |
| Home Phone | Hire Date | Occupation | | Coverage Eff Date | Date Employed |
| | | | | | |

**II. Plan Options for Plan Year 2007-2008 (Please check the appropriate box.)**
**Benefits will begin on your 91st day of Employment**

| Medical Elections: | Dental Elections: | Dependent Life: | Vision Elections: | Waiver (Refusal of Coverage) |
|---|---|---|---|---|
| | | | | Medical: Myself ☐ My Spouse ☐ |
| Plan 1 ☐ | PDN/PPO ☐ | Yes** ☐ | Yes ☐ | My Child(ren) ☐ |
| Plan 2 ☐ | DMO ☐ | No ☐ | No ☐ | Dental: Myself ☐ My Spouse ☐ |
| Plan 3 ☐ | | Amount: ___________ | | My Child(ren) ☐ |
| | | | | Vision: Myself ☐ My Spouse ☐ |
| Employee Only ☐ | EO ☐ | Supplemental Life: | EO ☐ | My Child(ren) ☐ |
| Employee & Child(ren) ☐ | ECH ☐ | Yes* ☐ | ECH ☐ | Life: Myself ☐ My Spouse ☐ |
| Employee & Spouse ☐ | ESP ☐ | No ☐ | ESP ☐ | My Child(ren) ☐ |
| Employee & Family ☐ | FAM ☐ | Amount: ___________ | FAM ☐ | |

**If Yes, Please make sure that dependents are listed below

*Life Amounts in excess of $50,000 will be taxable to the employee

**III. Member Information (PLEASE PRINT AND COMPLETE ALL INFORMATION)**

Indicate if you or your dependents are enrolling for medical or dental coverage by completing the boxes below.

| mes of everyone applying for coverage | Social Security | Date of Birth | Gender |
|---|---|---|---|
| Employee | | | |
| Spouse | | | |
| Child | | | |
| Child | | | |
| Child | | | |
| Child | | | |

**IV. Beneficiary Information (PLEASE PRINT AND COMPLETE ALL INFORMATION)**

| Beneficiary Name | Relationship | Social Security# | Date of Birth |
|---|---|---|---|
| | | | |

**I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS THE APPLICABLE CONTRIBUTION(S) FOR COVERAGE CHOSEN ABOVE.**

Employee Signature ______________________ Date ______________

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the future, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have new dependents as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself or your dependents in the future, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

**I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.**

Employee Signature ______________________ Date ______________


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| | |
| Yearly Maximum | $1,500 |
| CYD~Individual/Family | $50/$150 |
| Office Visit Co-Pay | N/A |
| | |
| Preventative | 100% |
| Basic | 80% |
| Major | 50% |
| On PPO there is a 12 month wating period for Major Services. | |
| Ortho | 50% |
| Ortho~Lifetime Max | $1,000 |
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| | |
| Spectacle Lenses | |
| Standard Single Vision | Covered in Full |
| Standard Bifocal | Covered in Full |
| Standard Trifocal | Covered in Full |
| Standard Lenticular | Covered in Full |
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| Co-Pay | |
| Vision Examination | $10.00 |
| Materials | $10.00 |
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