Total Rewards 2011

Children's® Healthcare of Atlanta

Health Plan Comparison

The chart below gives you a comparison of the two different health plan options. **You should review this chart, along with the additional information provided, and evaluate which plan works best for you.**

Benefit Highlight	Anthem/BCBS CDHP		BCBS Open Access POS	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Deductible Individual/family	$1,200/$2,400	$1,200/$2,400	$300/$600	$600/$1,200
Co-insurance Percent plan pays	80%	60%	90%	70%
Out-of-pocket Max Individual/family (excludes copays and deductible)	$1,800/$3,600	$2,800/$5,600	$2,200/$4,400	$4,400/$8,800
Office Visit Copay (including maternity visits)	You pay 20% after deductible	You pay 40% after deductible	$30	You pay 30% after deductible
Specialist Copay	You pay 20% after deductible	You pay 40% after deductible	$40	You pay 30% after deductible
Preventive Care	You pay 0%	You pay 40% after deductible	You pay 0%	You pay 30% after deductible
Inpatient Admission	You pay 20% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 30% after deductible
Emergency Department	You pay 20% after deductible	You pay 40% after deductible	$125 copay	$125 copay
Outpatient Surgery	You pay 20% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 30% after deductible
Prescription Drugs (Retail) 30-day supply				
Generic Brand Name Nonformulary	You pay 20% after deductible	You pay 40% after deductible	$10 30% co-insurance up to max of $75 45% co-insurance up to max of $100	$10 30% co-insurance up to max of $75 45% co-insurance up to max of $100
Prescription Drugs (Mail Order) 90-day supply				
Generic Brand Name Nonformulary	You pay 20% after deductible	N/A	2.5 times 30-day supply retail cost	2.5 times 30-day supply retail cost
Payroll Deductions (Each Pay Period/Annual)				
Employee	**$20/$520**		**$39/$1,014**	
Employee +1	**$58/$1,508**		**$95/$2,470**	
Family	**$86/$2,236**		**$142/$3,692**	

Important notes:

- Employees who do not complete their health screenings and health profiles on Strong4Life will pay $10 more per pay period than the rates noted above.
- Employees (as well as covered spouses and/or dependent children) who use tobacco in any form will pay $20 more per pay period per user (up to thre users per family).
- Employees who elect to cover his or her spouse who has access to health coverage through his or her own employer will pay $25 more per pay period than the rates noted above.
- All regular full-time employees with an annual salary of $30,000 or less will receive an automatic credit every pay period: $2 for single, $5 for employee +1 and $8 for family.

Vision Plan

Provider: Vision care is provided by Avesis.

Eligibility: If your employment status is regular full-time or regular part-time, you are eligible to participate in this benefit. Eligible dependents include your spouse and unmarried children up to age 19 (up to age 26 if a full-time student). Student dependents older than age 19 become ineligible for coverage on their birthday following graduation or when they are no longer full-time students.

Coverage Begins: The first of the month following 30 days of employment.

Cost: The payroll deductions (shown in the chart below) are based on the type of coverage you select (employee, employee +1, family). Your contributions will be deducted from your paycheck on a pretax basis.

Benefit Highlight	In-network *(Includes Private Practitioners and Retail Chain Stores)*	Out-of-network *(Reimbursement)*
Vision Examination *(once every 12 months)*	$10 copay	$40
Optical Materials	$15 copay *(spectacle lenses, frames)*	
Spectacle Lenses* *(per pair/once every 12 months)*		
Standard Single Vision	Covered 100%	$40
Standard Bifocal	Covered 100%	$60
Standard Trifocal	Covered 100%	$80
Specialty Lenses *(per pair/once every 12 months)*	20% discount off retail, minus plan payment	See above reimbursements
Tints/Coatings	20% discount off retail	$0
Frames *(once every 24 months)*	Covered within plan allowance*	$45
*The Avesis plan payment is $50 toward the wholesale cost. Retail value of this benefit is approximately $100 to $150.		
Contact Lenses* *(once every 12 months)*		
Elective**	$130 for contact lenses and professional services *(fitting fees)*	$130
Necessary	Covered 100%	$250
*Contact lenses are in lieu of spectacle lenses and a frame in accordance with the benefit period. ** $130 elective contact lens allowance may be applied toward contact lenses or professional services (fitting fees). You may use the $130 in increments throughout the plan period of 12 months for disposable contact lenses, not to exceed $130.		
Payroll Deductions (Each Pay Period/Annual)		
Employee	**$2.63/$68.38**	
Employee +1	**$5.03/$130.78**	
Family	**$8.03/$208.78**	

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Dental Plan

Provider: Dental care is provided by Blue Cross Blue Shield.

Eligibility: If your employment status is regular full-time or regular part-time, you are eligible for dental benefits. Eligible dependents include your spouse and unmarried children up to age 19 (age 26 if a full-time student). Student dependents older than age 19 become ineligible for coverage on their birthday following graduation or when they are no longer full-time students. You do not need to be enrolled in the health plan to enroll in the dental plan.

Coverage Begins: The first of the month following 30 days of employment.

Cost: The cost of the program is shared by you and Children's. Payroll deductions (shown below) are based on the coverage you select (employee, employee +1, family). Your contributions will be deducted from your paycheck on a pretax basis.

Making Changes: As described within Flexible Benefits Plan on Page 44.

Participating Dentist: BCBS provides you the option to select any dentist you want from inside or outside the network. By visiting a participating dentist, you can take advantage of lower out-of-pocket expenses for most preventive and major dental services, and should not be subject to amounts more than the reasonable and customary limit. Visit www.bcbsga.com to locate a participating dentist.

Predetermination of Benefits: Predetermination of benefits is recommended for all procedures for which the bill is expected to be $350 or more. You should contact your provider for a pretreatment estimate.

Excluded Procedures: See the Summary Plan Description on Careforce Connection for a list of procedures that are not covered.

Type of Service	The Plan Pays
Preventive Dental Benefits exams, cleanings *(once every six months)*, X-rays, fluoride treatments	100% of covered expenses up to the calendar year plan maximum; no deductible *(cleanings are covered once every six months)*
Basic Dental Benefits fillings, extractions, root canal work, periodontal treatment	80% of covered expenses after deductible up to the calendar year plan maximum
Major Dental Benefits crowns, dentures	50% of covered expenses after deductible up to the calendar year plan maximum
Orthodontia Benefits	50% of covered expenses; no deductible
Annual Deductible	$50 per individual
Calendar Year Plan Maximum	$1,500 per individual
Lifetime Orthodontia Plan Maximum	$1,500 per individual
Payroll Deductions (Each Pay Period/Annual)	
Employee Employee +1 Family	**$11/$286** **$22/$572** **$34/$884**

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