

PAULDING COUNTY HOSPITAL

Employee Benefit Overview - 2009

| PPO NETWORKS: Lutheran Preferred | |
|--|--|
| <i>Lifetime Maximum</i> | \$1,000,000.00 |
| <i>Deductible</i> | Individual In Network/Out of Network Family In Network/Out of Network |
| <i>Wellness Deductible Credit</i> | <p>\$ 50 Deductible Credit for Online Health Risk Assessment Completed by January 31st/ or within 30 days of eligibility</p> <p>\$50 Deductible Credit for Physical Assessment(Blood Draw, Blood Pressure Check, and BMI) . Completed by January 31st/ or within 30 days of eligibility</p> |
| <i>Coinsurance %</i> | At PCH In Network Out Network |
| <i>Out-of-Pocket Maximum</i> <i>(does not include the Deductible)</i> | Individual In Network/Out of Network Family In Network/Out of Network |
| <i>Office Visit</i> | In Network Out Network |
| <i>Supplemental Accident</i> | 100% up to \$300 |
| <i>Wellness</i> | At PCH In Network Out Network |
| <i>Mental/Nervous</i> | Inpatient Outpatient |
| <p><i>All non-emergency services and surgeries (professional and OB services excluded) must be performed at PCH, except for those procedures that PCH is not equipped to provide. Those claims performed outside of PCH (even if in-network) will be subject to deductible and 50% coinsurance.</i></p> <p><i>All services billed by "Paulding County Hospital" will be paid at 90% after deductible. Any professional fees billed by a provider (even if the service was performed at PCH) will be paid at 80% after deductible. Services provided in the Medical Office Building will be paid at 80% after deductible.</i></p> | |
| <i>Prescription Drugs-Formulary</i> | Generic at PCH Generic at PCH 3 month supply Brand at PCH Brand at PCH 3 month supply |
| <i>Prescription Drugs-Non-Formulary</i> | 1 month supply 3 month supply |
| <p><i>All prescriptions must be filled through Paulding County Hospital except:</i></p> <p>1) Traveling over 50 miles outside of the PCH area</p> <p>2) Student over 50 miles away from PCH area</p> <p>3) Paulding County Hospital Pharmacy closed</p> <p><u>Prescription Co-pay</u> for any of the above situations is:</p> <ul style="list-style-type: none"> • Prescription drug expense of \$200.00 or less <ul style="list-style-type: none"> ○ Participant will pay a \$30.00 copay • Prescription drug expenses of more than \$200.00 <ul style="list-style-type: none"> ○ Participant will pay 20%, of amount over \$200.00, in addition to the \$30.00 copay | |

| Group Term Life/AD&D (this benefit is automatically covered for all employees working 24+ hours per pay) | |
|---|----------------|
| Management | 2 times salary |
| Full Time | 1 times salary |
| Part Time | \$5,000 |

*Optional Term Life Insurance for Management and Full Time employees is subject to a minimum of \$5,000 and a maximum (including employer paid term life) of \$150,000.

| Optional Dependent Life Benefits | |
|---|---------|
| Spouse | \$5,000 |
| Child birth to 6 months | \$1,000 |
| Child 6 months to 19 or 25 if full time student | \$2,500 |

| Optional Dental Benefits | |
|---------------------------------|--|
| Deductible | \$50 |
| Preventative Dental Care | 100% no deductible |
| Basic Care | 80% after deductible |
| Major Care | 50% after deductible |
| Calendar Year Maximum | \$1,500 |
| Orthodontics | Included, with a Lifetime Maximum of \$1,500 |

| Optional Vision Benefits | |
|---------------------------------|---|
| Eye Exam | \$20 copay for exam every 12 months |
| Frames | \$20 copay for frames every 12 months |
| Lenses | \$20 copay for lenses (glasses or contacts) every 12 months |

Health Insurance Rates for Employees per pay period

Full Time Rates (Employees that work 72 or more hours per pay period)

| | |
|---------------------|----------|
| Single | \$20.00 |
| Employee/Child(ren) | \$88.00 |
| Employee/Spouse | \$95.00 |
| Family | \$116.00 |

Part Time Rates (Employees that work at least 40 but less than 72 hours per pay period.)

| | |
|---------------------|----------|
| Single | \$28.00 |
| Employee/Child(ren) | \$132.00 |
| Employee/Spouse | \$143.00 |
| Family | \$173.00 |

Optional Life Insurance Rates Per \$1,000 of coverage

| Age Brackets | Rate per \$1,000 | Age Bracket | Rate per \$1,000 |
|--------------|------------------|---------------|------------------|
| Under 30 | \$0.09 | 55-59 | \$0.80 |
| 30-34 | \$0.10 | 60-64 | \$1.00 |
| 35-39 | \$0.11 | 65-69 | \$1.75 |
| 40-44 | \$0.17 | AD&D all ages | \$0.03 |
| 45-49 | \$0.27 | | |
| 50-54 | \$0.45 | | |

Optional Dependent Life Cost per Month

| | |
|-----------------|--------|
| Monthly Premium | \$1.58 |
|-----------------|--------|

Optional Dental Coverage Rates - Per Pay Period

| | | | |
|-----------------|------------------------------|--------------------------|--------------------------|
| Single: \$11.50 | Employee/Child(ren): \$20.75 | Employee/Spouse: \$20.75 | Employee/Family: \$27.50 |
|-----------------|------------------------------|--------------------------|--------------------------|

Optional Vision Coverage Rates - Per Pay Period

| | | | |
|----------------|---------------------------|-------------------------|--------------------------|
| Single: \$5.50 | Employee/Child(ren): 9.50 | Employee/Spouse: \$9.25 | Employee/Family: \$15.25 |
|----------------|---------------------------|-------------------------|--------------------------|

IMPORTANT

This explanation of benefits is only intended to give an overview of the general benefits. It in no fashion represents a contract or a complete interpretation of benefits. The booklet will provide details of the employee benefit program. Some benefits not payable at limits shown on this illustration for certain conditions. ALL BENEFITS MAY BE SUBJECT TO PRE-EXISTING LIMITATIONS.

Review your summary plan description for details of these limits and other contract provisions.