

GENERAL SYNOD, ARP - HEALTH BENEFITS PLAN

Medical Plan Summary

Benefit	Plan A		Plan B	
	Participating Provider	Non-Participating Provider	Participating Provider	Non-Participating Provider
Deductible * indicates deductible waived	\$750 Individual \$1,500 Family	\$750 Individual \$1,500 Family	\$1,250 Individual \$2,500 Family	\$1,250 Individual \$2,500 Family
Coinsurance	80%	60%	80%	60%
Out-of-Pocket Limit	\$3,000 Individual; \$6,000 Family	\$6,000 Individual; \$12,000 Family	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
Physicians Office Visits				
Primary Care	\$15 Copay	60%	\$20 Copay	60%
Specialty Care	\$30 Copay	60%	\$35 Copay	60%
Preventive Care				
First \$1,000 of covered expenses	100%*	60%	100%*	60%
Amounts over \$1,000	80%	60%	80%	60%
Prescription Drugs (Provided by Caremark)				
Generic/ Preferred/ Non-Preferred (Up to a 31 day supply)	\$10/\$20/\$35 Copays		\$10/\$20/\$30 Copays	
Mail-In (up to a 90 day supply)	\$20/\$40/\$40 Copays		\$20/\$40/\$40 Copays	
Weight Reduction	Voluntary Enrollment Program. Plan will pay for cost of participation.			
Smoking Cessation	Voluntary Enrollment Program. Plan will pay for cost of participation.			
24 Hour Nurse Advisor 888-521-2583	Available 24 hours per day/Seven days per week.			

Vision Plan Summary

Benefit	Frequency	Participating Providers	Non-Participating Providers
Eye Examination	12 Months	100% after \$15 co-pay	\$35
Lenses (Standard Plastic) Single Vision/Bifocal/Trifocal	24 Months	100%	\$25/\$40/\$55
Lens Treatment Options	Unlimited	\$15-\$65; 20% off retail on other add-ons and services	N/A
Frames Up to \$110 retail value	24 Months	100%	\$55
Contact Lenses- Therapeutic In lieu of lenses and frames Up to \$110 retail value	24 Months	100% up to \$110; 20% of balance over allowance	\$200
Contact Lenses - Elective In lieu of lenses and frames Up to \$110 retail value	24 Months	100%	\$88
Additional Pairs of Eyeglasses/ Contact Lenses	Unlimited	Vision ONE discount available	N/A

Dental Plan Summary

Benefit	
Deductible	\$50 Individual \$150 Family
Applies to type II and III services	
Coinsurance	
Preventive (I) exams/deanings/x-rays	100%
Basic (II) fillings/extractions	80%
Major (III) crowns/bridges/dentures	50%
Calendar Year Maximum	
Applies to type I, II & III services	\$1,500
Orthodontic Services (IV)	50%
Lifetime Maximum (IV)	\$1,500

Life Benefit Summary

Term Life Insurance and Accidental Death Benefit	
Eligible Class	Benefit
Erskine Employees	\$10,000
Non-Erskine Salaried Employees	\$50,000
Non-Erskine Hourly Employees	\$20,000
Dependents age 15 days to 6 months	\$200
Dependents age 6 months and older (no Accidental Death)	Spouse \$5,000 Children \$2,500

LTD Benefit Summary

Long Term Disability Insurance (Erskine Employees Excluded)	
Waiting period after onset of disability	90 days
Benefit for total disability	60% of earnings
* Maximum monthly benefit	\$7,500