DENTAL BENEFITS

BENEFIT PROVISIONS	YOU PAY
Deductible	**$50 Individual / $150 Family**
Annual Maximum	**$1,500**
Diagnostic & Preventive Services	**Plan Pays 100%** Not subject to deductible
•Oral Examinations (2x per calendar year) •Routine or Periodontal Cleanings (2x per calendar year) •X-rays •Space Maintainers (through age 15)	•Flouride Application (2x per calendar year through age 18) •Emergency Pain Relief Treatment •Sealants (through age 15)
Basic & Restorative Services	**20%** after deductible
•Amalgam Fillings •Composite Resin Fillings •Stainless Steel Crowns •Extractions	•Oral Surgery •Endodontics •Periodontics •General Anesthesia
Major Services	**50%** after deductible
•Crowns •Cast Restorations	•Prosthodontics •Implants
Orthodontic Services	**50%** deductible does not apply
•Orthodontics (to age 19)	•$1,500 Lifetime Maximum

EMPLOYEE COST FOR DENTAL COVERAGE
Please contact Human Resources for Rate Information.

LIFE/AD&D BENEFITS

BENEFIT PROVISION	YOU PAY
Employee: $25,000 in Life Insurance + $25,000 in AD&D Spouse: $2,000 in Life Insurance Child(ren): $1,000 in Life Insurance	**FULLY PAID FOR BY EL CENTRO**

MEDICAL BENEFITS

BENEFIT PROVISIONS	SMART CARE 750	SMART CARE 750 (NO RX)
Calendar Year Deductible	**$750** Individual / **$2,250** Family	
Out-of-Pocket Maximum	**$2,000** Individual / **$6,000** Family	
Lifetime Maximum	**Unlimited**	
Primary Care Provider Services	**$30** Copay	
Speciality Physician Services	**$40** Copay	
Preventive Services	(PCP) **$30** Copay ; (Specialist) **$40** Copay	
Allergy Services (Testing & Serum)	**30%** after deductible is met	
Inpatient Hospital	**30%** after deductible is met	
Outpatient Surgery	**30%** after deductible is met	
Lab and X-Ray	*Included in Copay for applicable visit/facility charge* **No Additional Charge**	
MRI/PET/CAT Scans	**$50** Copay	
Substance Abuse (Inpatient Only)	*Detox Only* **30%** after deductible is met	
Emergency Room	**$100** Copay	
Urgent Care	**$40** Copay	
Durable Medical Equipment	*$2,000 Calendar Year Maximum* **50%** after deductible is met	
Rx Benefit	**$10** Generic **$20** Brand Formulary **$40** Brand Non-Formulary **15%** to a $250 Max for Specialty	No Benefit for Prescription Drugs

EMPLOYEE COST FOR MEDICAL COVERAGE
El Centro Family Health contributes towards the cost of your Medical Benefit Plan based on your FTE status. Please contact Human Resources for Rate Information.

VOLUNTARY BENEFITS

Cancer Policy Benefits: First Occurrence, Annual Wellness, Radiation & Chemotherapy, Hospital Confinement
Personal Disability: Income Replacement 3-24 Months
Life Insurance: Voluntary Group Term Life, Whole Life, Universal Life/Long Term Care Rider, Term Life
Hospital Confinement: Wellness, Admission, Outpatient Surgery, Rehabilitation Benefits/Intensive Care
Critical Illness: Wellness, Lump Sum Payment-Cancer, Heart Attack, Stroke, Major Organ Transplant, End Stage Renal Failure
Accident Coverage: Initial Care, Common Injuries, Surgical Care, Transportation, Accident Hospital Care, Follow-up Care, AD&D, Catastrophic Accident, Coverage 24/7/365

VISION BENEFITS

BENEFIT PROVISIONS	YOU PAY	
	In-Network	Out-of-Network
Annual Exam Deductible	$10	$10
Annual Materials Deductible	$25	$25
Eye Examination (Once every 12 Months)	Plan Pays 100%	$47 Maximum
Frames (Once every 24 Months)	$105 Maximum Allowable (+ discount if more expensive frame is selected)	$45 Maximum
Spectacle Lenses (Once every 12 Months) •**Single Vision** •**Bifocal Lenses** •**Trifocal Lenses** •**Lenticular Lenses**	**Plan Pays** 100% after annual materials deductible	(Maximum) $48 Allowable $69 Allowable $85 Allowable $125 Allowable
Contact Lenses (Necessary)- (Once every 12 Months)	**Plan Pays 100%**	$210 Maximum Allowable
Contact Lenses (Elective)- (Once every 12 Months)	$105 Maximum Allowable	$105 Maximum Allowable

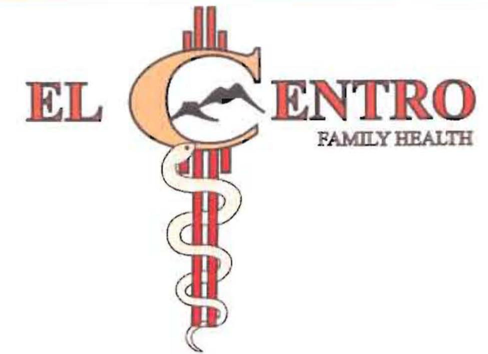
EMPLOYEE COST FOR VISION COVERAGE
Please contact Human Resources for Rate Information.

DISCLAIMER: This brochure has been prepared for you to use as an "at-a-glance" reference to your benefits. It is intended for summary purposes only. In all cases only the official plan documents control the administration and operation of the plans. This brochure does not constitute a contract of employment.

CONTACT INFORMATION

If you have any questions or need more information about El Centro's Employee Benefit Plans, please contact any one of the following:

EL CENTRO FAMILY HEALTH	**Human Resources**	**505.747.5927 or 505.747.5909**
	Payroll	**505.747.5910**
PRESBYTERIAN	**Medical**	**800.356.2219**
DELTA DENTAL	**Dental**	**877.395.9420**
AMERITAS	**Vision (through Vision Service Plan)**	**800.877.7195**
The Standard	**Life/AD&D**	**800.628.8600**
Colonial Life *Making benefits count.*	**Voluntary Benefits** **Rita Ribas**	**800.800.6992**
AON	**Benefits Consulting** **Michelle Urish or David Esquibel**	**800.432.5882 or 505.889.6700**



YOUR 2009 BENEFIT GUIDE

El Centro Family Health takes your healthcare and benefits plan seriously. That is why we take time each year to review your benefits and options. We strive to provide you quality benefits while balancing the cost of benefits for you.

The following summarizes El Centro's 2009 benefits package. There is a brief description of each plan. Once your coverage begins, it will remain in effect for the remainder of the plan year. You may make changes to your coverage only during the annual enrollment period unless you experience a qualified family status change. If you are eligible and you choose to NOT participate in any of the benefit plans, you MUST sign a waiver.

You are eligible for these benefits if you work 20 or more hours per week. The effective date for these benefits is the first of the month following completion of 30 days of employment.

January 1, 2009 - December 31, 2009