2022 ADT BENEFIT & PREMIUM SUMMARY

The following is a list of all benefits provided to or for American Diagnostic Technologies' full-time employees:

1. **Health Insurance** (Blue Cross Blue Shield) – Portion of employee premium paid by ADT.
2. **Dental Insurance** (Sun Life Financial) – Portion of employee premium paid by ADT.
3. **Vision Insurance** (Sun Life Financial) – Portion of employee premium paid by ADT.

All amounts are responsible by employee on a **monthly basis**

TYPE OF COVERAGE	HEALTH	DENTAL	VISION	MONTHLY TOTAL
Employee Only	$200	$20	$8	$228
Employee + One	$570	$54	$20	$644
Employee + Family	$740	$70	$24	$834

4. **Term Life Insurance** (Sun Life Financial, $15,000) – Employee premium paid 100% by ADT.
5. **Short Term Disability** (Sun Life Financial) – Employee premium paid 100% by ADT.
6. **Long Term Disability** (Sun Life Financial) – Employee premium paid 100% by ADT.
7. **Voluntary Additional Insurance** (Sun Life Financial) – Sun Life Financial offers eligible employees additional coverage for Accident, Cancer, Critical Illness, and Term Life Insurance. Any of these policies may be purchased in addition to the employee's other benefits. The employee is responsible for 100% of the premiums associated with electing additional supplemental coverage. This is paid via bi-weekly payroll deductions.
8. **Retirement Plan** (Ameritas 401k) – See enclosed information for further general details of eligibility and participation, or log onto www.Ameritas.com
9. **Vacation, holiday, etc. –** See last page for list of holidays and PTO accrual guidelines. See pages 34-35 of Corporate Employee Handbook for policies for requesting time off and claiming PTO.

Notes: Upon termination of employment, former employee will be eligible for 60 days to elect Cobra plan for current health, dental, vision, and supplemental insurance coverages and all premiums will become the sole responsibility of the former employee at full cost of current premium rates.

Employee becomes eligible for Health, Dental, Vision & Voluntary coverages on the 1st of the month following the first month of employment; 401(k) eligibility begins on the 1st of the month following 12 months of consecutive full time employment; Company paid supplemental coverages following the first year of consecutive Full Time employment.

www.BCBSLA.com - Group #: 78E66ERC

Blue Cross Blue Shield

GroupCare– PPO 1250

Health Policy Summary

Benefit Description	Preferred Provider Organization	
	In-Network	**Out of Network**
Calendar Year Deductible Individual Family	 $1,250 $3,750	*Does not apply toward "in-network" deductible* $1,250 $3,750
Maximum Out of Pocket Individual Family	 $5,000 $10,000	*Does not apply toward "in-network" deductible* $5,000 $10,000
Coinsurance	80%	60%
Physician In-Office Visits Primary Care / Specialist / Urgent Care Preventative Care / Immunization	 $40 Copay per visit 100% Covered before deductible	 60% after deductible
Wellness Option	100% Covered *(with limitations)*	n/a
Physician Inpatient & Outpatient Services	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
Hospital Inpatient Coverage	80% after deductible	60% after deductible
Hospital Outpatient Coverage	80% after deductible	60% after deductible
Accidental Injury Benefit	Up to $350	60% after deductible
Diagnostic X-Ray & Laboratory	80% after deductible	60% after deductible
Mental & Nervous Disorders Inpatient *Limitation*	 80% after deductible	 60% after deductible
Prescription Drug Card *Refer to the contract for applicable supply limitations* *Retail – up to 30 day supply* *Mail Order – up to 90 day supply* *[Prescription Drug Deductible]* *Specialty or non-formulary drugs*	 Generic $7 / Preferred Brand $30 Generic $21 / Preferred Brand$90 *[$100 per family member/per Calendar Year]* *20% of the cost – employee responsible*	
Employee becomes eligible for coverage on the 1st of the month following the first month of employment.		

Providers for this PPO plan are listed in the BlueCross & Blue Shield of Louisiana GroupCare Provider Network Directory or any Blue Cross & Blue Shield Blue Card PPO directory nationwide.

This outline is presented for general FAQ information only.
If there is any discrepancy between this document and the Benefit Plan, the provisions of the Benefit Plan will govern.

BCBSLA Customer Service: 1-800-599-2583 *Express Script Customer Service: 1-866-781-7533*

www.SunLifeConnect.com – Group #: 923154

SUN LIFE FINANCIAL
Dental Policy Summary

TYPES OF COVERAGE	COVERAGE AMOUNTS
Annual Deductible	
Employee	$50 per calendar year
Family (up to 3 persons individually)	$50 per person per calendar year
The individual deductible does not apply to Class I Dental Services	
Benefit Maximums	
Benefit Year Maximum per Person	$1,000
Overall Benefit Maximums for TMJ	$1,000
Co-Insurance Percentages	
Class A, Preventative Services *Limited to one visit every 6 months and 1 set of bitewing x-rays per calendar year.*	100%
Class B, Basic Services	80%
Class C, Major Services	50%
Class D, Orthodontics	50%
Carryover Benefits	$250
Threshold Limit	$500
Carryover Account Maximum	$1,000
Employee becomes eligible for coverage on the 1st of the month following the first month of employment.	

www.VSP.com – Group #: 923154

SUN LIFE FINANCIAL
Vision Policy Summary

TYPES OF COVERAGE	PARTICIPATING PROVIDER COPAYS	OUT OF NETWORK ALLOWANCES
Vision Care Services		
Exam *(Once per 12 month period)*	$10	Up to $52
Materials – Eye Glass Lenses *(once per 12 month period)*		
Single Vision	Covered	Up to $55
Bifocal	Covered	Up to $75
Trifocal	Covered	Up to $95
Lens Options:		
Scratch Resistant Coating	N/A	N/A
Polycarbonate Lenses for Children	N/A	N/A
Materials – Frames *(Once per 24 month period)*		
Members choose from any frame available at Providers locations.	$130 retail frame allowance and 20 % off the amount over your allowance.	Up to $57 retail
Materials – Contact Lenses *(once per 12 month period)*	$130 allowance for contact lens exam (fitting and evaluation) and materials. If you choose contact lenses you will be eligible for frames 12 months from the date the contact lenses were obtained.	Up to $105 retail
Elective *Contact lenses are in place of lenses and frame.*		
Employee becomes eligible for coverage on the 1st of the month following the first month of employment.		

SUN LIFE FINANCIAL
Long-Term Disability Benefit

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee Only	60% of employee income
Employee becomes eligible for coverage on the 1st of the month following the first year of consecutive full time employment.	

SUN LIFE FINANCIAL
Short-Term Disability Benefit

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee Only	60% of employee income
Employee becomes eligible for coverage on the 1st of the month following the first year of consecutive full time employment.	

SUN LIFE FINANCIAL
Term-Life Policy Benefit

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee	$15,000
Family: *(only available if employee has dependent coverage through ADT)*	
Spouse	$5,000
Children	$2,000
Employee becomes eligible for coverage on the 1st of the month following the first year of consecutive full time employment.	

SUN LIFE FINANCIAL
Voluntary Supplemental Policy Options

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee *May choose to elect additional voluntary insurance.* *Available policies may include, but are not limited to:* *Term Life* *Cancer* *Critical Illness*	*Benefit amounts vary based upon the choices made for coverage by the employee.* *Register for your Online Advantage at www.SunLifeConnect.com and click on "Products and Services" for detailed information.*
Employee becomes eligible for coverage on the 1st of the month following the first year of consecutive full time employment.	

www.Ameritas.com

AMERITAS – 401(k) Retirement Plan

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee *(May contribute up to 25%)*	*Employee may contribute up to IRS limits:* **Deferral Limit is $18,000 per year* ***Age 50 or older Deferral Limit is $24,000 per year*
Employee becomes eligible for coverage on the 1st of the month following 12 months of consecutive full-time employment.	

ACCRUED PAID TIME OFF & HOLIDAYS

See policy manual for more details regarding eligibility and policy procedures

TERMS OF BENEFIT	BENEFIT AMOUNTS
CONSECUTIVE FULL-TIME SERVICE COMPLETED 0 – 1 years 1 – 5 years 5+ years	**ACCRUAL HOURS PER PAY PERIOD** 2.15 hours 3.38 hours 4.30 hours
SICK TIME ACCRUAL *(per pay period)*	1.85 hours
COMPANY APPROVED PAID HOLIDAYS	New Year's Day Good Friday Independence Day Labor Day Thanksgiving Day Christmas Day

PAID HOLIDAY (if on weekend):
Holidays occurring on Saturday will be observed the Friday before.
Holidays occurring on Sunday, will be observed the Monday following.

Notes:

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Employee becomes eligible for Health, Dental, Vision & Voluntary coverages on the 1st of the month following the first month of employment; 401(k) eligibility begins on the 1st of the month following 12 months of consecutive full time employment; Company paid supplemental coverages following the first year of consecutive Full Time employment.

Disclaimer: This information is being provided as a summary only. Where discrepancies may exist, your plan documents will prevail.