2015 Medical & Dental Benefit Summary - Carespring Health Care Management

Employee Contributions Per Month			
Gold Plan		Bronze Plan Medical Mutual of Ohio (MMO)	
Single	$150	Single	$98
Employee +1	$300	Employee +1	$196
Employee +2 or More	$450	Employee +2 or	$294

Medical Benefits

		GOLD PLAN		BRONZE PLAN
		Option 1 - St.Elizabeth/ TriHealth/Cinti. Children's Hospital/Kettering Health Network*	Option 2 - The Christ Hospital/ Cinti. Children's Hospital/Kettering Health Network*	MMO Network
Deductible per Plan Year May 1st - April 30th	• Individual	$0		$5,000
	• Family	$0		$10,000
Out-of-Pocket Maximum per Plan Year *Includes Deductible, Coinsurance & Copays for medical expenses May 1st - April 30th	• Individual	$4,000		$6,600
	• Family	$8,000		$13,200
Covered Services		**Gold Plan Pays:**		**Bronze Plan Pays:**
Preventive Care				
• Adult Routine Physicals & Immunizations		Covered at 100%		Covered at 100%
• Preventive Lab & X-ray		Covered at 100%		Covered at 100%
• Preventive Colonoscopy		Covered at 100%		Covered at 100%
• Prostate Screening		Covered at 100%		Covered at 100%
• Well Woman PAP, Gynecological Exam & Mammogram		Covered at 100%		Covered at 100%
• Child Routine Physicals & Immunization		Covered at 100%		Covered at 100%
Physician Services				
•Office Visits - Primary Care Physician (Option 1)		100% after $20 Copay		100% after $20 Copay
•Office Visits - Primary Care Physician (Option 2)		100%		100% after $20 Copay
•Office Visits - Specialist		100% after $20 Copay		100% after $30 Copay
• Injections in Physician's Office		100% after $25 Copay		60% after deductible
• Urgent Care		100% after $20 Copay		100% after $40 Copay
Hospital Services				
• Inpatient Hospital per Admission (includes Maternity)		100% after $500 Copay		60% after deductible
• Emergency Room Services		100% after $200 Copay		60% after deductible
DON'T FORGET - YOU AND ALL OF YOUR FAMILY MEMBERS HAVE FREE ACCESS TO BOARD CERTIFIED DOCTORS THROUGH CADR+ - CALL 1-800-DOC-CONSULT				
Outpatient Services				
• Physical, Occupational & Speech Therapy (45 visits each plan year)		100% after $50 Copay		60% after deductible
• Cardiac Rehabilitation		100% after $50 Copay		60% after deductible
• Outpatient Surgery Facility		100%		60% after deductible
• Outpatient Dialysis, Chemotherapy & Radiation		100% after $50 Copay		60% after deductible
• MRI & PET Scans		100% after $250 Copay		60% after deductible
• CT Scans		100% after $150 Copay		60% after deductible
Other Medical Services				
• Chiropractic Care (max $1,000 per Plan Year)		100% after $25 Copay		60% after deductible
• Skilled Nursing Facility (60 Days Per Plan Year)		100% after $100 Copay		60% after deductible
• Home Health Care (40 Visits Per Plan Year)		100%		60% after deductible
• Ambulance (emergency only)		100% after $50 Copay		60% after deductible
• Hospice Services (max $10,000 per Plan Year)		100%		60% after deductible
• Durable Medical Equipment ($2500 per device)		80%		60% after deductible
Prescription Drug Plan	**Prescription Drugs Retail (30 Day Supply)**			
Kroger Prescription Plans	Generic Drugs	$10 Copay		$5 Copay
	Brand Preferred	$40 Copay		Not available
	Non-Formulary	$60 Copay		Not available
	Specialty	25% up to $250 max per RX		Not available

If you choose the Gold Plan , you must also choose from one of the two premier provider systems*:

Option 1

TriHealth
www.trihealth.com

St. Elizabeth HEALTHCARE
www.stelizabeth.com

KETTERING Health Network *
http://www.ketteringhealth.org/

Option 2

The Christ Hospital Health Network
www.thechristhospital.com

KETTERING Health Network *
http://www.ketteringhealth.org/

For treatment required at non-participating facilities and providers, contact your Patient Advocate at 1-855-598-8783 (select 1). Your Patient Advocate is available to assist you Monday-Friday 8am-5pm

** Direct contract with Kettering Health Network has not been finalized.*

Dental Benefits

Deductible per Plan Year May 1st - April 30th Deductible applies to Class B, Class C and Class D Services Only	• **Individual** • **Family**	$50.00 $100.00
Maximum Benefit Amount Per Individual		
	For Class A, Class B and Class C Services Combined	$2,000 Per Plan Year
	For Class D - Benefit availale for Dependents under age 19	$1,500 per Lifetime
Class A - Preventive & Diagnostic Dental Services		
	• Routine Oral Exams - 1 exam each 6 months	Covered at 100%
	• 1 Bitewing x-ray every 12 months	Covered at 100%
	• 1 Full mouth x-ray every 60 months	Covered at 100%
	• Space maintainers for dependent children under 19	Covered at 100%
	• Emergency palliative treatment for pain	Covered at 100%
	• Fluoride treatments - under age 19 and 1 every 6 months	Covered at 100%
	• Sealants for dependent children under age 15	Covered at 100%
Class B - Basic Dental Services		
	• Dental x-rays not included in Class A	Covered at 80%
	• Oral surgery	Covered at 80%
	• Periodontics	Covered at 80%
	• Endodontics	Covered at 80%
	• Extractions	Covered at 80%
	• Recementing bridges, crowns or inlays	Covered at 80%
	• Antibiotic drugs	Covered at 80%
Class C - Major Dental Procedures - (12 months of continuous dental coverage is required to be eligible for Class C Services)		
	• Gold restorations	Covered at 50%
	• Installation of crowns	Covered at 50%
	• Installation of precision attachments for dentures	Covered at 50%
	• Addition of clasp or rest to dentures	Covered at 50%
	• Repair of crowns, bridgework and dentures	Covered at 50%
	• Rebasing or relining of dentures	Covered at 50%
Class D - Orthodontic Treatment and Appliances - (12 months of continuous dental coverage is required to be eligible for Class D Services)		
	• Orthodontia	Covered at 50%