2016 Medical & Dental Benefit Summary - Carespring Health Care Management

Employee Contributions Per Month	
Gold Plan	
Single	$98
Employee +1	$350
Employee +2 or more	$500

Medical Benefits

		GOLD PLAN Option 1 - St.Elizabeth/ TriHealth/Cinti. Children's Hospital/Kettering Health Network	GOLD PLAN Option 2 - The Christ Hospital/ Cinti. Children's Hospital/Kettering Health Network
Deductible per Plan Year May 1st - April 30th	• Individual	$0	
	• Family	$0	
Out-of-Pocket Maximum *Includes Copays for medical and RX expenses per Plan Year May 1st - April 30th	• Individual	$4,000	
	• Family	$8,000	
Covered Services		**Gold Plan Pays:**	
Preventive Care			
• Adult Routine Physicals & Immunizations		Covered at 100%	
• Preventive Lab & X-ray		Covered at 100%	
• Preventive Colonoscopy		Covered at 100%	
• Prostate Screening		Covered at 100%	
• Well Woman PAP, Gynecological Exam & Mammogram		Covered at 100%	
• Child Routine Physicals & Immunization		Covered at 100%	
Physician Services			
•Office Visits - Primary Care Physician (Option 1)		100% after $20 Copay	
•Office Visits - Primary Care Physician (Option 2 - Christ Hospital Physicians only)		100%	
•Office Visits - Primary Care Physician (Option 2 - Kettering Health and Cinti. Children's)		100% after $20 Copay	
•Office Visits - Specialist		100% after $25 Copay	
• Injections in Physician's Office		100% after $25 Copay	
• Urgent Care		100% after $40 Copay	
Hospital Services			
• Inpatient Hospital per Admission (includes Maternity)		100% after $500 Copay	
• Emergency Room Services		100% after $350 Copay	
Outpatient Services			
• Physical, Occupational & Speech Therapy (45 visits each plan year)		100% after $50 Copay	
• Cardiac Rehabilitation		100% after $50 Copay	
• Outpatient Surgery Facility		100%	
• Outpatient Dialysis, Chemotherapy & Radiation		100% after $50 Copay	
• MRI & PET Scans		100% after $250 Copay	
• CT Scans		100% after $150 Copay	
Other Medical Services			
• Chiropractic Care (max $1,000 per Plan Year)		100% after $25 Copay	
• Skilled Nursing Facility (60 Days Per Plan Year)		100% after $100 Copay	
• Home Health Care (40 Visits Per Plan Year)		100%	
• Ambulance (emergency only)		100% after $50 Copay	
• Hospice Services (max $10,000 per Plan Year)		100%	
• Durable Medical Equipment ($2500 per device)		80%	
Prescription Drug Plan	**Prescription Drugs Retail (30 Day Supply)**		
Kroger Prescription Plans	Generic Drugs	up to $15 Copay	
	Brand Preferred	$45 Copay	
	Non-Formulary	$65 Copay	
	Specialty	25% up to $300 max per RX	

All preventive care is covered (no cost to you!), so be sure to schedule your annual preventive visit with your primary care doctor

If you, or your someone on your plan gets sick - DON'T FORGET - YOU HAVE FREE ACCESS TO BOARD CERTIFIED DOCTORS THROUGH TELADOC - CALL 1-800-DOC-CONSULT. These doctors can treat many common conditions without requiring an office visit - FREE!

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

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

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%