Custom Design Benefits

2017 Medical Benefit Summary

Custom Design Benefits is our Third Party Administrator

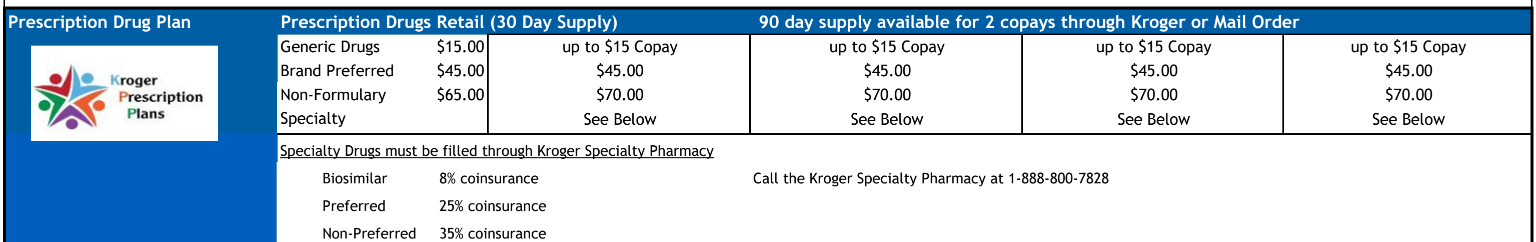
Customer Service: (800) 598-2929 or (513) 598-2929 or visit our website at www.CustomDesignBenefits.com

Patient Advocate: (855) 598-8783 or ProviderRequest@CareValent.com

Employee Contributions Per Month

Medical - Christ Hospital		Medical - Kettering		Medical - St. Elizabeth		Medical - TriHealth	
Employee Only	$102	Employee Only	$102	Employee Only	$114	Employee Only	$126
Employee +1	$360	Employee +1	$360	Employee +1	$400	Employee +1	$440
Employee + 2-3	$500	Employee + 2-3	$500	Employee + 2-3	$540	Employee + 2-3	$570
Employee + 4 or more	$550	Employee + 4 or more	$550	Employee + 4 or more	$580	Employee + 4 or more	$610

		Medical - Christ Hospital	Medical - Kettering	Medical - St. Elizabeth	Medical - TriHealth
Deductible	• **Individual**	$0	$0	$0	$0
May 1st - April 30th	• **Family**	$0	$0	$0	$0
Out-of-Pocket Maximum *Includes Copays for medical and RX	• **Individual**	$4,000	$4,000	$4,000	$4,000
per Plan Year	• **Family**	$8,000	$8,000	$8,000	$8,000
Covered Services		**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**
Preventive Care					
• Adult Routine Physicals & Immunizations		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Preventive Lab & X-ray		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Preventive Colonoscopy		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Prostate Screening		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Well Woman PAP, Gynecological Exam & Mammogram		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Child Routine Physicals & Immunization		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
Physician Services					
•Office Visits - Primary Care Physician		$0.00	$25.00	$25.00	$25.00
•Office Visits - Specialist		$40.00	$40.00	$40.00	$40.00
• Injections in Physician's Office		$30.00	$30.00	$30.00	$30.00
• Urgent Care		$50.00	$50.00	$50.00	$50.00
Hospital Services					
• Inpatient Hospital per Admission (includes Maternity)		$500/day up to 3 day max	$500/day up to 3 day max	$500/day up to 3 day max	$500/day up to 3 day max
• Emergency Room Services		$350.00	$350.00	$350.00	$350.00
Outpatient Services					
• Physical, Occupational & Speech Therapy (45 visits per plan year)		$50.00	$50.00	$50.00	$50.00
• Cardiac Rehabilitation		$50.00	$50.00	$50.00	$50.00
• Outpatient Surgery Facility/Physician's Office		$200.00	$200.00	$200.00	$200.00
• Outpatient Dialysis, Chemotherapy & Radiation		$50.00	$50.00	$50.00	$50.00
• MRI		$250 copay non-hospital/ $500 copay hospital	$250 copay non-hospital/ $500 copay hospital	$250 copay non-hospital/ $500 copay hospital	$250 copay non-hospital/ $500 copay hospital
• PET Scans		$500.00	$500.00	$500.00	$500.00
• CT Scans		$150 copay non-hospital/ $300 copay hospital	$150 copay non-hospital/ $300 copay hospital	$150 copay non-hospital/ $300 copay hospital	$150 copay non-hospital/ $300 copay hospital
Other Medical Services					
• Chiropractic Care (max $1,000 per Plan Year)		$25.00	$25.00	$25.00	$25.00
• Skilled Nursing Facility (60 Days Per Plan Year)		$100.00	$100.00	$100.00	$100.00
• Home Health Care (40 Visits Per Plan Year)		$25.00	$25.00	$25.00	$25.00
• Ambulance (emergency only)		$250 copay ground/$500 copay air	$250 copay ground/$500 copay air	$250 copay ground/$500 copay air	$250 copay ground/$500 copay air
• Hospice Services (max $10,000 per Plan Year)		$0.00	$0.00	$0.00	$0.00
• Durable Medical Equipment ($2500 per device)		20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance



Prescription Drug Plan

Kroger Prescription Plans

Prescription Drugs Retail (30 Day Supply)		90 day supply available for 2 copays through Kroger or Mail Order			
Generic Drugs	$15.00	up to $15 Copay	up to $15 Copay	up to $15 Copay	up to $15 Copay
Brand Preferred	$45.00	$45.00	$45.00	$45.00	$45.00
Non-Formulary	$65.00	$70.00	$70.00	$70.00	$70.00
Specialty		See Below	See Below	See Below	See Below

Specialty Drugs must be filled through Kroger Specialty Pharmacy

Biosimilar	8% coinsurance
Preferred	25% coinsurance
Non-Preferred	35% coinsurance

Call the Kroger Specialty Pharmacy at 1-888-800-7828

This summary of benefits is provided to give you a general overview of the plan. We have attempted to make this summary as up to date and accurate as possible. However, if there are any discrepancies between the summary and the plan documents, the plan documents will supersede this summary. If you want more detail about your coverage and costs, please see the complete Summary Plan Description (SPD).

Custom Design Benefits

2017 Dental Benefit Summary

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Employee Dental Plan Contributions Per Month	
Employee Only	$14
Employee +1	$24
Employee + 2-3	$30
Employee + 4 or more	$40

Deductible	● **Individual**	$50.00
per Plan Year		
May 1st - April 30th	● **Family**	$100.00
Deductible applies to Class B, Class C and Class D Services Only		
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%