

Oldcastle CDHP 2012 Benefit Summary

Plan Provisions	In-Network	Out-of-Network
Calendar Year Deductible	\$1,500 Employee \$2,250 Employee +1 \$3,000 Family	\$3,000 Employee \$4,500 Employee +1 \$6,000 Family
Out-of-Pocket Maximum – Per Calendar Year <i>Includes the Deductible</i>	\$4,000 Employee \$6,250 Employee + 1 \$7,500 Family	Unlimited
Health Care Account Contribution	\$500 Employee/\$750 Employee +1/\$1,000 Family	
Lifetime Maximum per Participant	Unlimited	
INPATIENT HOSPITAL SERVICES (must be preauthorized)	80%	60%
Penalty for Failure to Preauthorize	None	\$300
EMERGENCY ROOM/TREATMENT ROOM		
<i>Accident & Medical Emergency Situation within 48 hours</i>		
Facility Charges	80%	
Physician Charges	80%	
Urgent Care	80%	
Non-Emergency Situations		
Facility Charges	80%	60%
Physician Charges	80%	60%
MEDICAL-SURGICAL SERVICES		
Office	80%	60%
Physician Surgical Services Inpatient	80%	60%
Physician Surgical Services Outpatient	80%	60%
Facility Surgical Services Outpatient	80%	60%
Home Infusion Therapy (must be preauthorized)	80%	60%
In-Vitro Fertilization	Not Covered	
Chiropractic Care, in an office setting 20 visits per calendar year (combined in/out-of-network)	80%	60%
Physical, Occupational, and Speech Therapy 30 visits each per calendar year (combined in/out-of-network)	80%	60%
DIAGNOSTIC X-RAY AND LABORATORY SERVICES		
Outpatient	90%	60%
Independent Lab or X-ray	90%	60%

Plan Provisions	In-Network	Out-of-Network
PREVENTIVE CARE		
Routine Physicals/Well Baby Care/Mammograms/ Colorectal/Bone Density/PSA/Pap Smear/Cholesterol	100%*	Not Covered
OB/GYN and Immunizations	100%*	60%
EXTENDED CARE SERVICES (must be preauthorized)		
Home Health Care <i>120 Visits Per Calendar Year</i>	80%	60%
Skilled Nursing Facility <i>120 Days Maximum Per Calendar Year</i>	80%	60%
Hospice Care	80%	60%
<i>Benefits used in Network or Out-of-Network apply towards satisfying both maximums.</i>		
MENTAL HEALTH (MH)/CHEMICAL DEPENDENCY (must be preauthorized)		
<i>Inpatient Services</i>		
Hospital Services (Facility)	80%	60%
Physician Services	80%	60%
<i>Outpatient Services</i>		
Services Performed in Physician Office (Non-Surgical)	80%	60%
Emergency Room/Treatment Room/Facility Charges	80%	60%
Professional Provider	80%	60%

PRESCRIPTION DRUGS (Co-Pays Apply to Preventive Drug List Only, All other drugs subject to deductible)			
<i>Retail</i>	Minimum	% Coinsurance	Maximum
Generic	\$5	N/A	\$5
Formulary Brand	\$15	25%	\$50
Non-Formulary Brand	\$30	50%	\$125
<i>Mail Order</i>	Minimum	% Coinsurance	Maximum
Generic	\$10	N/A	\$10
Formulary Brand	\$30	25%	\$100
Non-Formulary Brand	\$60	50%	\$250

*Deductible Waived