2024 True Cost Benefit Summary

Effective January 1, your medical plan will be administered by Custom Design Benefits, a 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@PayerCompass.com

True Cost Benefit Summary

Deductible	• Individual	$0
per Benefit Period	• Family	$0
		You Pay:
Preventive Care	• Adult Routine Physicals	$0; Plan Pays 100%
	• Adult Routine Immunizations	
	• Preventive Lab & Xray	
	• Preventive Colonoscopy	
	• Prostate Screening	
	• Well Woman PAP & Gynecological Exam	
	• Mammogram Screening	
	• Child Routine Physicals & Routine Immunizations	
Physician Services	• Office Visits - PCP	$30 Copay
	• Office Visits - Specialist	$50 Copay
	• Urgent Care	$40 Copay
	• Injections in Physician's Office (excludes Allergy)	$30 Copay
	• Allergy Injections	$0
Hospital Services	• Inpatient Hospital	$250 Copay Per Day (3 Day Max)
	• Newborn Nursery	$250 Copay Per Day (3 Day Max)
	• Emergency Room Services	$200 Copay (waived if admitted)
Outpatient Services	• MRI	$250 Copay Imaging Center / $500 Copay Hospital
	• PET Scans	$500 Copay
	• CT Scans	$250 Copay Imaging Center / $500 Copay Hospital
	• Physical, Occupational & Speech Therapy	$50 Copay
	(60 Combined Visits Per Year)	
	• Pulmonary Rehab	$50 Copay
	• Cardiac Rehab (36 Visits Per Year)	$50 Copay
	• Outpatient Surgery	$250 Copay
	• Outpatient Dialysis, Chemotherapy & Radiation	$50 Copay
Other Medical Services	• Chiropractic Care (24 Visits Per Year)	$30 Copay
	• Diabetes Services & Education (3 visits per Year)	$30 Copay
	• Skilled Nursing Facility	$100 Copay
	• Home Health Care (60 Visits Per Year)	$50 Copay
	• Ambulance (Emergency Only, Ground & Air)	$250 Copay Ground / $500 Copay Air
	• Hospice Services	$0
	• Durable Medical Equipment	20% Copay

Prescription Drug Plan	Prescription Drugs Retail (30 Day Supply)		Prescription Drugs Mail Order (90 Day Supply)	
	Generic Drugs	$0	Generic Drugs	$0
	Brand Preferred	$35	Brand Preferred	$85
	Non-Preferred	Not Covered	Non-Preferred	Not Covered
	Specialty Drugs	$75		

	Annual Out of Pocket	• Individual	$2,500
	Maximum per Calendar Year	• Family	$5,000

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).