City of Sylvania Employee Healthcare Plan
Open Enrollment Quick Reference Summary
Effective January 1, 2012

Medical Coverage

Deductibles, Coinsurance And Maximums	In-Network Benefit	Out-of-Network Benefit
Calendar Year Deductible – Individual – Family	 $500 $1,000	 $500 $1,000
Coinsurance	80%	60%
Annual Maximum	$2,000,000	$2,000,000
Lifetime Maximum	Unlimited	Unlimited
Maximum Out-of-Pocket * – Individual – Family	 $2,000 $4,000	 $3,500 $7,000

***** The out-of-pocket maximum includes the deductible. The following do not apply to maximum out-of-pocket: copayment amounts, non-emergency room copayments, mental / nervous / chemical dependency, and non-covered items. Amounts satisfied toward the out-of-network, out-of-pocket limit will also be applied toward the in-network, out-of-pocket limit. Amounts satisfied toward the in-network, out-of-pocket limit will not be applied toward the out-of-network, out-of-pocket limit.

Covered Services	In-Network Benefit	Out-of-Network Benefit
Office Visits: Preventive Care Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits.		
• Routine Physical exam	1st $300 payable at 100%; charges in excess of $300 are payable at 80% (*not subject to deductible*)	1st $300 payable at 100%; charges in excess of $300 are payable at 60% (*not subject to deductible*)
• Well Baby Care (beginning after initial hospital discharge, up to age one)	1st $500 payable at 100% after $25 copayment; charges in excess of $500 are payable at 80% after deductible	1st $500 payable at 100% after $25 copayment; charges in excess of $500 are payable at 60% after deductible
Illness or Injury		
• Doctor's office visit	1st $500 payable at 100% after $25 copayment for PCP ($35 copayment for Specialist); charges in excess of $500 are payable at 80% after deductible	Plan pays 60% after deductible
• Chiropractic care (Limited to 26 visits per calendar year; not to exceed $50 in medical charges per visit)	$20 copayment, then plan pays 100%	Plan pays 60% after deductible
• Maternity physician services (prenatal, delivery, postpartum)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Supplemental accident benefit	1st $500 per accident payable at 100%; charges in excess of $500 are payable at 80% (*not subject to deductible*)	n/a
Emergency Room / Inpatient / Outpatient Services		
• Hospital emergency room (non-accident, non-emergency use)	$100 copayment, then plan pays 80% after deductible	$100 copayment, then plan pays 60% after deductible
• Inpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible
• Outpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible
Therapy Services		
• Mental / Nervous – Inpatient (Lifetime maximum of 30 days and will be reduced by any inpatient chemical dependency treatment days)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Mental / Nervous – Outpatient (Limited to 50 visits per calendar year and will be reduced by any outpatient chemical dependency treatment days)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Chemical Dependency – Inpatient (Lifetime maximum of 30 days and will be reduced by any inpatient mental / nervous treatment days)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Chemical Dependency – Outpatient (Limited to 50 visits per calendar year and will be reduced by any outpatient mental / nervous treatment days)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Physical (Limited to 26 visits per calendar year; not to exceed $60 in medical charges per visit)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Occupational	Plan pays 80% after deductible	Plan pays 60% after deductible
• Speech	Plan pays 80% after deductible	Plan pays 60% after deductible
• Bereavement Counseling	Limited to $200 per family unit	Limited to $200 per family unit

Other Services **Calendar year maximums are combined between in-network and out-of-network**		
• Podiatry / Orthotics (Maximum benefit of $500 per calendar year – including charges for physician, orthotics, or any custom made devices)	$35 copayment	Plan pays 60% after deductible
• DME / Prosthetics (Limited to 100 days of rental. Charges over $500 require prior authorization.)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Convalescent Care Facility (maximum 30 days per calendar year)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Home Health Care (maximum 100 visits per calendar year)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Hospice Care (Limited to $150 per day up to a lifetime maximum of $6,000. Outpatient hospice care is limited to a lifetime maximum of $4,000.)	Plan pays 80% after deductible	Plan pays 60% after deductible
PRESCRIPTION CO-PAYS (The greater of the flat-dollar copayment or coinsurance)	**RETAIL PHARMACY** (30 day supply only)	**MAIL ORDER** (60, 90 day supply)
GENERIC	$10	$10
BRAND	$20	$20
PRE-CERTIFICATION	This Plan covers only charges that are Medically Necessary for the care and treatment of disease or injury. To determine Medical Necessity, Core Health Services (CHS) requires that you obtain advance approval (pre-certification) for scheduled inpatient and outpatient hospital treatment and all services performed in an Ambulatory Surgical Facility or Specialized Treatment Facility (Oncology Center, Dialysis Facility, etc.). Please call CHS to see if your Outpatient Procedure requires Pre-certification. • Mental / Nervous and Chemical Dependency require notification. • Maternity (see separate Maternity Admissions) also requires notification. • Emergency services no longer require precertification (see separate Emergency or Urgent Inpatient or Outpatient Admissions). **PENALTY FOR FAILURE OF PRE-CERTIFICATION WILL RESULT IN AN ADDITIONAL FRONT END DEDUCTIBLE OF $300 ON THE ELIGIBLE FACILITY CHARGES.**	
EXCLUDED SERVICES	The following services are not covered: • Routine vision exam • Testing for ADD / Learning Disabilities • Congenital conditions or diseases causing delayed speech development in children	
EXCLUDED FACILITIES	Benefits will not be covered for the following excluded facility: The Doctors Hospital of Tattnall	