Dodge County Hospital 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	 $1,000 $3,000	 $2,000 $6,000
Coinsurance	80%	60%
Annual Maximum	$1,250,000	$1,250,000
Lifetime Maximum	Unlimited	Unlimited
Maximum Out-of-Pocket * – Individual – Family	 $5,000 $10,000	 $10,000 $30,000

***The following do not apply to maximum out-of-pocket: deductibles, copayment amounts, non-emergency room copayments, 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.

Primary network hospital is Dodge County Hospital (DCH) as well as physicians with admitting privileges to DCH.

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.		
• Annual physical exam	Plan pays 100% (*not subject to deductible*)	Not covered
• Eye exam	$100 calendar year maximum	Not covered
Illness or Injury		
• Doctor's office visit (includes allergy injections billed alone)	Plan pays 80% after $35 copayment (100% after $35 when performed by DCH Network Physician)	Plan pays 60% after deductible
• OB/GYN visit	Plan pays 80% after $35 copayment	Plan pays 80% after $35 copayment
• Chiropractic care	$25 copayment; $1,200 calendar year maximum	Plan pays 60% after deductible
• Maternity physician services (prenatal, delivery, postpartum)	Plan pays 80% after deductible	Plan pays 80% after deductible
• Newborn nursery care (included as expense of the baby)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Supplemental accident benefit	1st $500 per accident payable at 100%, then plan pays 80% after deductible	n/a
Emergency Room Services		
• Hospital emergency room (per visit)	$150 copayment	$150 copayment
• Hospital "per admission" deductible	$500 deductible	$1,000 deductible
Inpatient / Outpatient Services		
• Preadmission testing	Plan pays 80%	Plan pays 60% after deductible
• Physician services (anesthesiologist, radiologist, pathologist)	Plan pays 80% after deductible	Plan pays 60% after deductible
• X-ray and lab services (performed in Doctor's Office)	Plan pays 80% after deductible	Plan pays 60% after deductible
• X-ray and lab services (performed at Hospital or Free-standing Facility)	Plan pays 80% after deductible	Plan pays 60% after deductible
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges	Plan pays 80% after deductible	Plan pays 60% after deductible
Other Services **Calendar year maximums are combined between in-network and out-of-network**		
• Mental or Nervous Disorder; Substance abuse	Not covered	Not covered
• Skilled Nursing Facility	$3,480 calendar year maximum	$3,480 calendar year maximum
• Home Health Care	$2,500 calendar year maximum	$2,500 calendar year maximum
• Hospice Care	$10,000 calendar year maximum	$10,000 calendar year maximum
• Air Ambulance	Plan pays 60% 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 or 25% cost of drug after $150	$20 or 25% cost of drug after $150
PREFERRED	$30 or 30% cost of drug after $150	$60 or 30% cost of drug after $150
NON-PREFERRED	30% cost of drug under $150 50% cost of drug $150 and over	30% cost of drug under $150 50% cost of drug $150 and over
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. • Maternity (see separate Maternity Admissions) also requires notification. • Emergency services no longer require precertification (see separate Emergency or Urgent Inpatient or Outpatient Admissions). **MUST BE REPORTED TO CORE WITHIN 48 HOURS.** **PENALTY FOR FAILURE OF PRE-CERTIFICATION IS $1,000.**	
EXCLUDED SERVICES	The following services are not covered: • Genetic testing • Gastric bypass surgery	
EXCLUDED FACILITIES	Benefits will not be covered for the following excluded facilities: The Doctors Hospital of Tattnall, Women's Surgery Center in Statesboro, GA and Lower Oconee Community Hospitals.	