2025 Medical Benefit Summary

CARESPRING

Effective 5/1/2025

Custom Design Benefits

Group Number: CAR00

		Medical - Christ Hospital & Kettering Health Network	Medical - TriHealth	Medical - St. Elizabeth
		Employee Contributions Per Month		
Your medical is administered by Custom Design Benefits Customer Service: (800) 598-2929 or (513) 598-2929 or visit our website at www.CustomDesignBenefits.com Patient Advocate: (855) 598-8783		Employee Only $117 Employee + One $399 Employee + 1 (Spouse) $491 Employee + 2 or 3 $551 Employee + 2 or 3 (Spouse) $641 Employee + 4 or more $589 Employee + 4 or more (Spouse) $697	Employee Only $156 Employee + One $495 Employee + 1 (Spouse) $595 Employee + 2 or 3 $668 Employee + 2 or 3 (Spouse) $763 Employee + 4 or more $711 Employee + 4 or more (Spouse) $813	Employee Only $152 Employee + One $486 Employee + 1 (Spouse) $584 Employee + 2 or 3 $656 Employee + 2 or 3 (Spouse) $749 Employee + 4 or more $691 Employee + 4 or more (Spouse) $798
		The Christ Hospital Health Network / Kettering Health Network	TriHealth	St. Elizabeth Healthcare
Deductible	• Individual • Family	$0 $0	$0 $0	$0 $0
Out of Pocket Maximum *Includes Copays for medical and Rx copay expenses per Plan Year	• Individual • Family	$6,000 $12,000	$6,000 $12,000	$4,800 $9,600
Covered Services		**You Pay:**	**You Pay:**	**You Pay:**
Preventive Care				
• Adult Routine Physicals & Immunizations		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Preventive Lab & Xray		$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%
• Prostate Screening		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Well Woman PAP & Gynecological Exam		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Mammogram Screening		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
• Child Routine Physicals & Immunizations		$0; Plan Pays 100%	$0; Plan Pays 100%	$0; Plan Pays 100%
Physician Services				
• Office Visits - PCP		$30.00 waived if Christ Hospital Provider	$30.00	$30.00
• Office Visits - Specialist		$50.00	$50.00	$50.00
• Injections in Physician's Office		$30.00	$30.00	$30.00
• Urgent Care		$75.00	$75.00	$75.00
Hospital Services				
• Inpatient Hospital Per Admission (includes Maternity)		Christ Hospital $500/day up to 5 days max All others $600/day up to 5 days max	Christ Hospital $500/day up to 5 days max All others $600/day up to 5 days max	Christ Hospital $500/day up to 5 days max All others $600/day up to 5 days max
• Emergency Room Services		$500.00	$500.00	$500.00
Outpatient Services				
• Physical, Occupational & Speech Therapy (45 Combined Visits Per Year)		$30.00 waived if care provided at Carespring facility	$30.00 waived if care provided at Carespring facility	$30.00 waived if care provided at Carespring facility
• Cardiac Rehab (36 Visits Per Year)		$50.00	$50.00	$50.00
• Outpatient Surgery Facility/Physician's Office		Christ Hospital $250 All others $400	Christ Hospital $250 All others $400	Christ Hospital $250 All others $400
• Outpatient Dialysis, Chemotherapy & Radiation		$50.00	$50.00	$50.00
• MRI		$250 copay non-hospital/ $500 copay hospital owned	$250 copay non-hospital/ $500 copay hospital owned	$250 copay non-hospital/ $500 copay hospital owned
• PET Scans		$500.00	$500.00	$500.00
• CT Scans		$150 copay non-hospital/ $300 copay hospital owned	$150 copay non-hospital/ $300 copay hospital owned	$150 copay non-hospital/ $300 copay hospital owned
Other Medical Services				
• Chiropractic Care (max $1,000 per Plan Year)		$50.00	$50.00	$50.00
• Skilled Nursing Facility (60 Days Per Year)		$100 per day waived if staying at Carespring facility	$100 per day waived if staying at Carespring facility	$100 per day waived if staying at Carespring facility
• Home Health Care (40 Visits Per Year)		$30.00	$30.00	$30.00
• Ambulance (Emergency Only)		$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
• Durable Medical Equipment		20% coinsurance	20% coinsurance	20% coinsurance

Prescription Drug Plan		Prescription Drugs Retail (30 Day Supply)	90 day supply available for 2 copays through Magellan RX Mail Order	
Prime Therapeutics	Generic Drugs	up to $15 Copay	up to $15 Copay	up to $15 Copay
	Brand - Preferred	$60.00	$60.00	$60.00
	Brand - Non-Preferred	$70.00	$70.00	$70.00
	Specialty	See Below	See Below	See Below

Specialty Drugs must be pre-authorized

Biosimilar - 10% coinsurance; Preferred - 40% coinsurance; Non-Preferred 50% coinsurance

IMPORTANT INFORMATION FOR NON-SPECIALTY PRESCRIPTIONS: TrueCost RX may have an impact on one or more of your current medications. If you are impacted, RxResults will send you a personalized letter on behalf of the Carespring Healthcare Management Plan. The letter will include details on the impact and include contact information.

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).

5589 Cheviot Road Cincinnati, Ohio 45247
800.598.2929 513.598.2929
www.CustomDesignBenefits.com