Holy Family Memorial

2019 Health, Dental and Vision Plans

This is a summary only. Refer to your Plan Document for coverage details.

Holy Family Memorial

Sponsored by the Franciscan Sisters of Christian Charity

hfmhealth.org

Franciscan Health Benefit Plan 1

Administered by UMR—UnitedHealthcare

High deductible health plan—qualifies you to establish a Health Savings Account with unique tax advantages

Preventive Care Benefit for Employee, Spouse & Dependents—see complete schedule on the IntraLink
No annual Maximum, No Deductible or Co-Insurance if HFM Provider is used and per the Summary of Preventive Care Schedule.

	HFM Provider		UHC Choice Plus		Out of Network	
Employee Only	Deductible Coinsurance % Out of Pocket Max	$1,350 90/10 $2,200	Deductible Coinsurance % Out of Pocket Max	$1,350 75/25 $4,950	Deductible Coinsurance % Out of Pocket Max	$2,500 50/50 $12,400
Family	Deductible Coinsurance % Out of Pocket Max	$3,000 90/10 $5,500	Deductible Coinsurance % Out of Pocket Max	$3,000* 75/25 $11,100	Deductible Coinsurance % Out of Pocket Max	$6,000* 50/50 $27,200

***Plan 1 Only:**

- *If an Employee + 1 Child is enrolled, the employee will pay the EE + Child premium level, but must meet the Family deductible.*
- *Prescriptions are subject to the deductible, coinsurance and out of pocket maximum.*
- *Families must meet the full Family deductible before an individual's claim will be covered.*

REGULAR PREMIUM	Employee Only		EE + Child		Family	
	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays
Full-Time	$40.14	$286.24	$75.09	$577.67	$92.57	$723.38
Part-Time	$57.63	$268.75	$110.05	$542.71	$136.26	$679.69

DEDUCT $10 per pay period if you achieve the Wellness Incentive!

DISCOUNTED PREMIUM WITH WELLNESS INCENTIVE	Employee Only		EE + Child		Family	
	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays
Full-Time	$30.14	$296.24	$65.09	$587.67	$82.57	$733.38
Part-Time	$47.63	$278.75	$100.05	$552.71	$126.26	$689.69

Premiums are deducted 24 times per year.

You are responsible for verifying Provider status:

HFM Providers:
Holy Family Memorial employed providers—visit www.hfmhealth.org

UMR UHC Choice Plus Network (Intermediate)
Visit www.UMR.com Click on **Member** > Select **Find a Provider** > Select **UnitedHealthcare Choice Plus** in the provider list or call UMR customer service at (800) 826-9781 and enter your member ID (located on your medical card)

Out of Network
Global Care—Call (866) 807-6193 or (770) 667-0247

Pharmacy Providers
Preferred—HFM Pharmacy & HFM Medical Center Pharmacy
Intermediate—OptumRx network—visit www.optumrx.com

If you think you might be unable to meet a standard for an incentive under the wellness program, you may qualify for an opportunity to earn the same incentive by different means. Contact Employee Health Services at (920) 320-4026, who will work with you to find a wellness program with the same incentive that is right for you in light of your health status.

Franciscan Health Benefit Plan 2

Administered by UMR—UnitedHealthcare

Preventive Care Benefit for Employee, Spouse & Dependents—see complete schedule on the IntraLink

No annual Maximum, No Deductible or Co-Insurance if HFM Provider is used and per the Summary of Preventive Care Schedule.

	HFM Provider		*UHC Choice Plus*		*Out of Network*	
Employee Only	Deductible Coinsurance % Out of Pocket Max	$800 90/10 $1,725	Deductible Coinsurance % Out of Pocket Max	$800 75/25 $3,940	Deductible Coinsurance % Out of Pocket Max	$1,600 50/50 $9,890
Employee + Child	Deductible Coinsurance % Out of Pocket Max	$1,600 90/10 $3,050	Deductible Coinsurance % Out of Pocket Max	$1,600 75/25 $6,370	Deductible Coinsurance % Out of Pocket Max	$3,200 50/50 $15,755
Family	Deductible Coinsurance % Out of Pocket Max	$2,400 90/10 $4,370	Deductible Coinsurance % Out of Pocket Max	$2,400 75/25 $8,800	Deductible Coinsurance % Out of Pocket Max	$4,800 50/50 $21,620
Prescriptions (All Levels)	Generic Copay Brand Copay Minimum Brand Copay Maximum Brand Copay Coins. After Copay	$10 25% $15 $150 100%	Generic Copay Brand Copay Minimum Brand Copay Maximum Brand Copay Coins. After Copay	$20 30% $25 $172.50 100%	Generic Copay Brand Copay Minimum Brand Copay Maximum Brand Copay Coins. After Copay	$20 30% $25 $172.50 75%

REGULAR PREMIUM	*Employee Only*		*EE + Child*		*Family*	
	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays
Full-Time	$99.77	$253.49	$194.34	$512.19	$241.61	$641.54
Part-Time	$118.68	$234.58	$232.16	$474.37	$288.90	$594.25

DEDUCT $10 per pay period if you achieve the Wellness Incentive!

DISCOUNTED PREMIUM WITH WELLNESS INCENTIVE	*Employee Only*		*EE + Child*		*Family*	
	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays
Full-Time	$89.77	$263.49	$184.34	$522.19	$231.61	$651.54
Part-Time	$108.68	$244.58	$222.16	$484.37	$278.90	$604.25

Premiums are deducted 24 times per year.

Example of Plan Comparison

IMPORTANT NOTE: *This example is for illustration purposes only and is not a guarantee of payment or outcomes.*

Remember...consider the premiums you pay as well as your deductible, coinsurance and out of pocket maximum when evaluating what plan is right for you. **Contact HR for help evaluating which plan best meets your needs.**

Example: Assume you are a full-time employee with Employee Only health plan coverage. You incur a total of $2,000 in claims during the year using only HFM providers. In this case, Plan 1 is the most cost effective option for you. You pay a higher portion of the $2,000 in claims out of your pocket but you pay *significantly* less in premiums.

	Plan 1-EE Only	Plan 2-EE Only
Claims	$2,000.00	$2,000.00
Deductible—You Pay	***$1,350.00***	***$800.00***
Balance after deductible	$650.00	$1,200.00
Coinsurance	10%	10%
Coinsurance—You Pay	***$65.00***	***$120.00***
Total Claims—You Pay	***$1,415.00***	***$920.00***
Premium—You Pay	***$723.36***	***$2,154.48***
Your total expense including premiums	***$2,138.36***	***$3,074.48***

Franciscan Dental Plan—*Delta Dental*

Dental Service	*Benefit Level*
Diagnostic exams, preventative care & X-rays	100% (charges applied to annual maximum)
Direct fillings, general/local anesthesia, antibiotics, emergency repairs, root canals	80% (after a $50 deductible)
Crowns, dentures, orthodontics*	50% (after a $50 deductible)
**$1,500 lifteime orthodontic treatment for eligible dependents under age 19* *Annual maximum of $1,500 per person (includes charges for diagnostic exams, preventative care & x-rays)*	

For a complete list of Delta Dental Premier and PPO dentists, visit www.deltadentalwi.com

PREMIUM YOU PAY	*Employee Only*		*Family**	
	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays
All Eligible Employees	$9.15	$9.16	$28.56	$28.57

**Family = Employee plus one or more dependents*

Premiums are deducted 24 times per year.

Franciscan Vision Plan—*Superior Vision Insurance Plan of Wisconsin*

Service	*In Network*	*Out of Network*
Exams	100%	Up to $35 retail value
Frames	Up to $125 retail value	Up to $70 retail value
Lenses	100% (standard single, bifocal, trifocal)	$25—single, $40—bifocal, $45—trifocal
Contact Lenses (in lieu of frames and lens benefit)	Up to $150	Up to $125

For a complete list of network providers, visit www.visionplans.com

PREMIUM YOU PAY	*Employee Only*		*Limited Family**		*Family*	
	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays	You Pay Per Check	HFM Pays
All Eligible Employees	$2.08	$2.08	$4.16	$4.16	$5.51	$5.51

Limited Family = Employee + Spouse **or Employee + Child or Children*

Premiums are deducted 24 times per year.

CALL HUMAN RESOURCES AT 320-4031 AT ANY TIME WITH QUESTIONS ABOUT YOUR BENEFITS!

Premiums for health, dental and vision are automatically taken on a pre-tax basis as part of the Franciscan Section 125 Cafeteria Plan. If you wish to have your premiums deducted on an after tax basis, contact Human Resources.

IMPORTANT: This document is intended for summary purposes only. It does not contain all the details that apply to your benefits. For the details about your benefits, refer to the summary plan description for each benefit.