Holy Family Memorial

2020 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

HFM will be contributing to a Health Reimbursement Account (HRA)-$375 for Single/$1,000 for Family. This will reduce the deductibles to $1,675 for single/ $4,000 for Family.

	HFM Provider	UHC Choice Plus	Out of Network
Employee Only	Deductible $2,000 Coinsurance % 90/10 Out of Pocket Max $2,850	Deductible $2,000 Coinsurance % 70/30 Out of Pocket Max $6,500	Deductible $4,000 Coinsurance % 50/50 Out of Pocket Max $13,900
Family	Deductible $5,000 Coinsurance % 90/10 Out of Pocket Max $7,500	Deductible $5,000* Coinsurance % 70/30 Out of Pocket Max $13,800	Deductible $10,000* Coinsurance % 50/50 Out of Pocket Max $31,200

***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.*
- *Emergency Room visits have a $250 per occurrence charge.*

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	$44.46	$284.86	$98.90	$559.73	$122.83	$700.47
Percent Paid	13.5%	86.5%	15.0%	85.0%	15.0%	85.0%
Part-Time	$62.91	$266.41	$135.78	$522.85	$168.93	$654.37
Percent Paid	19.0%	81.0%	21.0%	79.0%	21.0%	79.0%

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	$34.46	$294.86	$88.90	$569.73	$112.83	$710.47
Percent Paid	10.5%	89.5%	13.5%	86.5%	14.0%	86.0%
Part-Time	$52.91	$276.41	$125.78	$532.85	$158.93	$664.37
Percent Paid	16.0%	84.0%	19.0%	81.0%	19.0%	81.0%

Premiums are deducted every pay period.

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

Franciscan Health Benefit Plan 2

Administered by UMR—UnitedHealthcare

	HFM Provider		UHC Choice Plus		Out of Network	
Employee Only	Deductible Coinsurance % Out of Pocket Max	$1,000 90/10 $1,925	Deductible Coinsurance % Out of Pocket Max	$1,000 70/30 $4,950	Deductible Coinsurance % Out of Pocket Max	$2,000 50/50 $10,290
Employee + Child	Deductible Coinsurance % Out of Pocket Max	$2,000 90/10 $3,450	Deductible Coinsurance % Out of Pocket Max	$2,000 70/30 $7,950	Deductible Coinsurance % Out of Pocket Max	$4,000 50/50 $16,555
Family	Deductible Coinsurance % Out of Pocket Max	$3,000 90/10 $4,970	Deductible Coinsurance % Out of Pocket Max	$3,000 70/30 $11,000	Deductible Coinsurance % Out of Pocket Max	$6,000 50/50 $22,820
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	$15 30% $25 $172.50 100%	Generic Copay Brand Copay Minimum Brand Copay Maximum Brand Copay Coins. After Copay	$15 30% $25 $172.50 75%

• *Emergency Room visits have a $250 per occurrence charge.*

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	$100.65	$267.30	$198.09	$537.81	$246.79	$672.94
Percent Paid	27.0%	73.0%	27.0%	73.0%	27.0%	73.0%
Part-Time	$118.41	$249.54	$233.63	$502.27	$291.22	$628.51
Percent Paid	32.0%	68.0%	32.0%	68.0%	32.0%	68.0%

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	$90.65	$277.30	$188.09	$547.81	$236.79	$682.94
Percent Paid	26.0%	74.0%	26.0%	74.0%	26.0%	74.0%
Part-Time	$108.41	$259.54	$223.63	$512.27	$281.22	$638.51
Percent Paid	30.0%	70.0%	30.0%	70.0%	30.0%	70.0%

Premiums are deducted every pay period.

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) 320-4689, 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 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	$8.45	$8.45	$26.37	$26.37

**Family = Employee plus one or more dependents*

Premiums are deducted every pay period.

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	$1.92	$1.92	$3.84	$3.84	$5.09	$5.09

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

Premiums are deducted every pay period.

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.