GHT

WCA GROUP HEALTH TRUST

Renewal for Waterford Graded School District

(9/01/16)

	Renewal Plan	
PPO Network	UHC Choice+	
Deductible	*Deductibles Separate*	
In Network	$2,000/4,000	
Out of Network	$4,000/8,000	
Coinsurance		
In Network	100%	
Out of Network	80%	
Maximum Out of Pocket (Medical & Coinsurance Only)		
In Network	$2,000/ 4,000	
Out of Network	$5,250/10,500	
Maximum Out of Pocket ***With OV Copayments***		
In Network	$3,000/6,000	
Out of Network	Unlimited	
Preventative Exam	100%	Ded/80%
Hospitalization	Ded/100%	Ded/80%
Office Visit(s)	$25/Ded/100%	$50/Ded/80%
Specialist Office Visit(s)	$25/Ded/100%	$50/Ded/80%
Chiropractic Office Visits(s)	$25/Ded/100%	$50/Ded/80%
Physical, Occupational, Speech Therapy	$25/Ded/100%	$50/Ded/80%
Urgent Care	$50/Ded/100%	$50/Ded/ 80%
Emergency Room Care	$100/Ded/100%	$100/PPO Ded/ 100%
All Other Medical Services	Ded/100%	Ded/80%
High Tech Imaging Coverage	Ded/100%	Ded/80%
Pharmacy		
Drug Plan *Retail and Mail Order	$0/10/25/50 – 34 Day Supply $0/30/75/150- 90 Day Retail Supply $0/20/50/100 – 90 Day Mail Order Supply Mandatory Generic Applies	
Maximum Out of Pocket (Pharmacy Only)	$2,000/4,000	
Include Erectile Dysfunction Benefits	Yes	
Optional Benefits		
Vision Benefits	Yes	
Waiver of Premium	Yes	
Health Premium		
Single	$ 688.00	
Family	$1,583.00	
Medicare Single w/Rx	$ 468.00	
Medicare Family w/Rx	$ 936.00	
Medicare Special w/Rx	$1,223.00	
Medicare Single w/o Rx	$ 157.00	
Medicare Family w/o Rx	$ 335.00	
Dental Premium		
Single	$ 50.00	
Family	$ 127.00	

2017-2018
Health and Dental Deductions and Benefits per check

Health Care GHT Deduction per check

	2017 18 Renewal and Monthly Premium	24 pay (DO, admin, some teachers) 15%	20 pays (support staff, some teachers) 15%
		0.15	0.15
Single	655	49.125	58.95
Family	1507	113.025	135.63

Health Care GHT benefit per check

	2017 18 Renewal and Monthly Premium	24 pay (DO, admin, some teachers) 85%	20 pays (support staff, some teachers) 85%
		0.85	0.85
Single	655	278.375	334.05
Family	1507	640.475	768.57

Dental GHT deduction per check

	2017 18 Renewal and Monthly Premium	24 pay (DO, admin, some teachers) 15%	20 pays (support staff, some teachers) 15%
		0.15	0.15
Single	50	3.75	4.5
Family	127	9.525	11.43

Dental GHT benefit per check

	2017 18 Renewal and Monthly Premium	24 pay (DO, admin, some teachers) 85%	20 pays (support staff, some teachers) 85%
		0.85	0.85
Single	50	21.25	25.5
Family	127	53.975	64.77

UMR: WATERFORD GRADED SCHOOL DISTRICT JOINT #1: 76-440122 001

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling 1-800-826-9781. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person / **$4,000** family In-network **$4,000** person / **$8,000** family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	**$2,000** person / **$4,000** family In-network **$5,250** person / **$10,500** family Out-of-network annual deductible & coinsurance out-of-pocket maximum **$1,000** person / **$2,000** family In-network **Unlimited** person / **Unlimited** family Out-of-network annual medical and prescription copay out-of-pocket maximum	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay per visit	$50 Copay per visit; 20% Coinsurance	None
	Specialist visit	$25 Copay per visit	$50 Copay per visit; 20% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	20% Coinsurance Preventive care & screening; No charge; Deductible Waived Immunization	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com.	Generic drugs (Tier 1)	$10 for a 30 day supply, retail; $30 for a 31-90 day supply, retail; $20 for up to a 90 day supply, mail order	$10 for a 30 day supply, retail; $30 for a 31-90 day supply, retail; $20 for up to a 90 day supply, mail order	Deductible waived. Prescriptions on the Value Priced Drug List have no copay. There is no copay for diabetic test strips, lancets or syringes. Prescription drug out-of-pocket maximum: $2,000 person / $4,000 family. *This is included in the medical out-of-pocket maximum shown on page 1.* If a member chooses a Non-Preferred Drug when a Generic is available, the member will pay the cost difference between the two tiers plus the Non-Preferred copay. *Note: Specialty prescriptions can only be obtained through a CVS Pharmacy or by CVS Caremark mail order to a maximum 30-day supply, retail or mail order.
	Preferred brand drugs (Tier 2)	$25 for a 30 day supply, retail; $75 for a 31-90 day supply, retail; $50 for up to a 90 day supply, mail order	$25 for a 30 day supply, retail; $75 for a 31-90 day supply, retail; $50 for up to a 90 day supply, mail order	
	Non-preferred brand drugs (Tier 3)	$50 for a 30 day supply, retail; $150 for a 31-90 day supply, retail; $100 for up to a 90 day supply, mail order	$50 for a 30 day supply, retail; $150 for a 31-90 day supply, retail; $100 for up to a 90 day supply, mail order	
	Specialty drugs (Tier 4)	Applicable copay tier applies*	Applicable copay tier applies*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% Coinsurance	None
	Physician/surgeon fees	No charge	20% Coinsurance	None
If you need immediate medical attention	Emergency room care	$100 Copay per visit	$100 Copay per visit	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	Emergency medical transportation	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Urgent care	$50 Copay per visit	$50 Copay per visit; 20% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service.
	Physician/surgeon fee	No charge	20% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$25 Copay per office visit; No charge other outpatient services	$50 Copay per visit; 20% Coinsurance office visit; 20% Coinsurance other outpatient services	None
	Inpatient services	No charge	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	20% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% Coinsurance	
	Childbirth/delivery facility services	No charge	20% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% Coinsurance	60 Maximum visits per calendar year
	Rehabilitation services	$25 Copay per visit	$50 Copay per visit; 20% Coinsurance	20 Maximum visits per calendar year OT; 20 Maximum visits per calendar year PT; 20 Maximum visits per calendar year ST
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	20% Coinsurance	30 Maximum days per confinement; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service.
	Durable medical equipment	No charge	20% Coinsurance	None
	Hospice service	No charge	20% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids (to age 18)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient care)
- Routine eye care (adult)
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan Provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet the Minimum Value Standard? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.
800-826-9781.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$2,120**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$220
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$7,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,700
Copayments	$210
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,910**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.