

Medical Insurance

Current rates in effect for 2018-2019 are as follows:

	Healthcare Rates	Employee Contribution Monthly
Single	\$851.23	\$127.68
Employee + Spouse	\$1,696.73	\$254.51
Employee + Children	\$1,544.54	\$231.68
Family	\$2,204.03	\$330.60

The School District purchases a high deductible insurance plan through Medical Mutual Insurance. The plan covers major medical and prescription coverage. The District then funds the employee claims as they occur through a 3rd party administrator: Barrett Benefits.

The current plan has deductibles as follows for inside network:

	<u>Deductible</u>	<u>Max Out of Pocket</u>	<u>Reimbursement Deductible</u>
Single:	\$5,000	\$1,000	\$ 500
Family:	\$10,000	\$2,000	\$1,000

Once the employee reaches the reimbursement deductible, Barrett Benefits reimburses the employee directly 80% of their claims cost until they reach the max out of pocket and then Barrett will reimburse 100% of the employee claims. The maximum out of pocket that an employee will pay is Single: \$1,000 and Family: \$2,000. After the Medical Mutual deductible is reached, Medical Mutual pays 100% towards claims.

Claims can be processed by Barrett Benefits two ways:

1. You can fax or mail your Explanation of Benefits (EOB) to Barrett at:
Fax (866) 539-5643
Mail to: Barrett Benefits
3628 Walnut Hills Road Suite 200
Orange Village, Ohio 44122
(866) 845-8600 Option 1
Sharefund@bbginc.net
2. You can complete MMO Authorization that will allow Barrett Benefits to retrieve your EOBs from the Medical Mutual website on a weekly basis.

Prescription Drug Reimbursements require that you submit a copy of the pharmacy tag (usually comes stapled to your prescription) and the receipt to Barrett Benefits.

Any questions regarding claims for Barrett Benefits can be emailed to Kathy Salsbury at ksalsbury@bbginc.net or she can be reached by phone at (866) 845-8600 Option 1

The Treasurer's office, once a week, receives a list of claims that will be paid by Barrett Benefits. The Treasurer's office does not see any claim detail, they only see the employee's name and a dollar amount. The Treasurer's office then forwards payment to Barrett Benefits, and they in turn process a check to the employee. Please note Barrett Benefits is a licensed 3rd party administrator through the State of Ohio. Barrett Benefits is subject to strict audit and bonding requirements from the State of Ohio. Your claims are held in the strictest confidence and actual claims are never seen by staff in the Treasurer's Office.

A copy of the Medical Mutual coverage summary is attached.

Dental Insurance

Dental Insurance is provided through a self-insurance program. Guardian Insurance is the servicing company that pays claims on the District's behalf. Claims are submitted to Guardian Insurance and paid directly to the provider. Once per month, Guardian provides a list of claims paid on our behalf. The claims are reviewed for accuracy and the money is debited from the District's Dental account on the 25th of each month.

A copy of the Guardian Dental coverage summary is attached.

Group Number 464513

Optical Insurance

Employees are entitled to a \$350 reimbursement for optical expenses incurred by an employee or employee's eligible dependents. Original receipts must be submitted, along with a completed Optical Reimbursement Form, to the Treasurer's office for reimbursement.

Life Insurance

Life insurance coverage is available to employees of the District. Employees should consult their negotiated agreement for coverage amounts.

Important Dates

Medical Insurance Coverage Period:

Plan Year – August 1 through July 31

Coverage Year – January 1 through December 31

Dental Insurance Coverage Period:

Plan Year – August 1 through July 31

Coverage Year – January 1 through December 31

Optical Reimbursement Period: September 1st through August 31st

Flexible Savings Account: January 1st through December 31st
With a grace period until March 15

Waiver Deadline: August 25th of the new School Year

Waiver Payment: The First pay date in September of the following year
(Opt out employees are not eligible for Dental insurance and Optical Reimbursements)



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, call 800-232-7400. 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 MedMutual.com/SBC or call 800-232-7400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$5,000/single,\$10,000/family Network \$10,000/single,\$20,000/family Non-Network	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>preventive care</u> and all services with <u>copayments</u> are covered and paid by the <u>plan</u> before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$6,600/single,\$13,200/family Network \$20,000/single,\$40,000/family Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Cost sharing</u> for <u>prescription drugs</u> , <u>premiums</u> , balance-billed charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, See MedMutual.com/SBC or call 800-232-7400 for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Specialist visit</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Diagnostic test</u> (blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at MedMutual.com/SBC	Generic copay - retail Tier 1	\$10 after <u>deductible</u>	Does Not Apply	Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	\$25 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	\$50 after <u>deductible</u>	Does Not Apply	Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	\$125 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	\$90 after <u>deductible</u>	Does Not Apply	Covers up to a 30-day supply.
	Non-preferred brand copay - home delivery Tier 3	\$225 after <u>deductible</u>	Does Not Apply	Covers up to a 90-day supply.
	<u>Specialty drugs</u>	30% after <u>deductible</u> up to \$250 maximum	Does Not Apply	Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees (Outpatient)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% coinsurance		None
	<u>Emergency medical transportation</u>	20% coinsurance		None
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/ surgeon fee (inpatient)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits		None
	Inpatient services	Benefits paid based on corresponding medical benefits		None
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	(100 visits per benefit period)
	<u>Rehabilitation services</u> (Physical Therapy)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	(20 visits per benefit period)
	<u>Habilitation services</u> (Occupational Therapy)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	(20 visits per benefit period)
	<u>Habilitation services</u> (Speech Therapy)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	(20 visits per benefit period)
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	(100 days per benefit period)
	<u>Durable medical equipment</u>	50% coinsurance		None
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	50% <u>coinsurance</u>	None
	Children's glasses		Not Covered	Excluded Service
	Children's dental check-up		Not Covered	Excluded Service

Excluded Services & Other Covered Services:

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

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- Routine Eye Care (Adult)

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: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform, your state insurance department at 800-686-1526 and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 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: the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform, your state insurance department at 800-686-1526 or your plan at 800-232-7400.

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 Minimum Value Standards? 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.

-----*To see examples of how this plan might cover costs for sample medical situations, see the next section*-----

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

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** \$5,000
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$30
Coinsurance	\$1,500

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$6,590
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$5,000
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$200
Coinsurance	\$20

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Joe would pay is	\$5,280
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$5,000
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$1,900
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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: 800-232-7400.

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



Summary of Benefits

Dental Benefit Summary

Group ID:	00464513	Coverage Type:	Contributory
Group Name:	BERKSHIRE LOCAL SCHOOL DISTRICT	Class:	0003 ALL OTHER ELIGIBLE EMPLOYEES WORKING 32 OR MORE HOURS PER WEEK
Waiting Period:	None	As of Date:	08/17/2018

Plan Information

Your dental networks is: Dental - DentalGuard Pref NAP - Ohio

Coverage Information

	Dental - DentalGuard Pref NAP - Ohio	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the Dental - DentalGuard Pref NAP - Ohio network will be most cost effective.	
	In Network	Out of Network
Calendar year deductible	Out of Network is a combined deductible for in and out of network services.	\$25, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive		Waived
Basic		Not Waived
Major		Not Waived
Calendar Year Maximum Benefit	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	\$1,000
Lifetime Orthodontia Maximum	The amount shown in the out of network field is your combined Lifetime Orthodontia Maximum for both in and out of network services	\$1,000
Maximum rollover	Yes	Yes
Monthly Switch	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?(as a percentage of reasonable and customary.)
Office Visit Co-pay (one office visit may cover multiple services)	None	None
Preventive Care:	100%	100%

	Dental - DentalGuard Pref NAP - Ohio	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the Dental - DentalGuard Pref NAP - Ohio network will be most cost effective.	
	In Network	Out of Network
Bitewing X-Rays	100%	100%
Full Mouth X-Rays	100%	100%
Cleaning	100%	100%
Oral Exams	100%	100%
Sealants (per tooth)	100%	100%
Basic Care:	80%	80%
Fillings (one surface)	80%	80%
General Anesthesia ¹	80%	80%
Scaling & Root Planing (per quadrant)	80%	80%
Simple Extractions	80%	80%
Major Care:	50%	50%
Dentures	50%	50%
Single Crowns	50%	50%
Orthodontia	80%	80%

General Exclusions

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans:


This policy provides dental insurance only. Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury.

Deductibles apply.

The plan does not pay for:

- Oral hygiene services (except as covered under preventive services),
- Orthodontia (unless expressly provided for),
- Cosmetic or experimental treatments (unless they are expressly provided for).
- Any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment.

The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DEN -16 et al.

 ¹ Restrictions apply and may be subject to medical necessity.

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

Definitions shown on this site are in summary form and are for general informational purposes. The terms of the insurance contract prevails.