2020/2021 TROY CITY SCHOOLS HEALTH BENEFITS PLAN

PPO **Claims Administrator: UMR, Inc. (1-800-826-9781)** **PPO**

Per-pay contributions for medical coverage Medical Plan Year: Jul 1 - Jun 30	**Certified** Employee $65.03 Employee/Spouse $136.57 Employee/Children $110.56 Family $195.10	**Classifed** Employee $56.90 Employee/Spouse $119.50 Employee/Children $96.74 Family $170.71
Plan Feature	**PPO**	**Non-PPO**
Deductible - Per Individual	$400 per Plan Year (July 1 to June 30)	$800 per Plan Year (July 1 to June 30)
Deductible - Per Family	$800 per Plan Year	$1600 per Plan Year
Out-of-Pocket Maximum Per Individual	$1000 per Plan Year Including the deductible	$3000 per Plan Year Including the deductible
Out-of-Pocket Per Family	$2000 per Plan Year Including the deductible	$6000 per Plan Year Including the deductible
Most Inpatient and Outpatient Services	80% of PPO rate, subject to deductible	60% of UCR, subject to deductible
Physician Office Visit	100% of PPO rate after $15 co-payment	60% of UCR, subject to deductible
Emergency Room	100% of PPO rate after $100 co-payment	100% of UCR after $100 co-payment
Preventative Care	100% of PPO rate	60% of UCR, subject to deductible;
Lifetime Maximums per Plan Participant		Unlimited
Annual Maximums per Plan Participant per Plan Year	45 days for Inpatient Mental Health and Substance Abuse Care combined $1000 for Chiropractic Care $5000 for RN and LPN Outpatient Services 60 Home Health Care Nursing Visits	
Prescription Drug Card (maximum 34-day supply)	Generic: 100% after $5.00 co-payment Brand Name, Preferred: 100% after $15 co-payment Brand Name, Non-Preferred: 100% after $25 co-payment	
Prescription Drug Mail Service (maximum 90-day supply)	Generic: 100% after $10.00 co-payment Brand Name, Preferred: 100% after $30 co-payment Brand Name, Non-Preferred: 100% after $50 co-payment	
Vision Care (one of each service per Plan Year)	100% coverage; $15 co-payment for Eye Exams; covers first $50 for single vision lenses, $75 for bifocal lenses, $75 for trifocal lenses, $75 for lenticular lenses, $100 for contact lenses, and $50 for frames	
UMR **1-800-826-9781** **www.umr.com**		**United Health Care** **Find a provider at www.umr.com** Select **United Health Care Choice Plus Network** from the pull-down menu

DENTAL PLAN Dental Plan Year: Jan 1 - Dec 31

Maximum benefit each CALENDAR YEAR for Class I, II and III Services	$1,500.00
Lifetime maximum for orthodontic services, per person	$2,000.00
Individual Deductible	$25.00
Family Maximum Deductible	$50.00

Percentages (of usual and customary) payable for covered dental procedures:

Class I	100%	Class III	60%
Class II	80%	Class IV	60%

Guardian **Find a provider at www.guardiananytime.com** **1-888-600-1600**