Greenfield Union School District

2021-2022

Benefit Summary & Bargaining Unit Caps

Active GTA

J. GLYNN & Company
Healthcare Advisory Services

2021-2022 Health Benefits Summary

2021-2022 Plan Benefits	CVT Blue Shield PPO 2B	CVT Blue Shield PPO 5B	CVT Blue Shield PPO 6B	CVT Blue Shield PPO 8B	CVT Blue Shield PPO Wellness 1	CVT Blue Shield PPO BRONZE
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	$0/$0	$100/$200	$250/$500	$500/$1,000	$500/$1,000	$5,000/$10,000
Individual/Family Out-of-Pocket (OOP) Max *(includes medical deductibles, co-insurance and co-pays)*	$1,250/$2,500	$1,250/$2,500	$2,000/$4,000	$3,250/$6,500	$1,750/$3,500	$6,350/$12,700
PROFESSIONAL SERVICES						
Office Visit (OV) co-pay	$20	$30	$20	$30	$20	First 3 $60 Ded. Waived, then 30% after Ded.
Urgent Care co-pay	$20	$30	$20	$30	$20	$120 after Ded.
Specialists/Consultants co-pay	$20	$30	$20	$30	$40	$70 after Ded.
Prenatal, postnatal office visit co-pay	$20	$30	$20	$30	$20	30% after deductible
Scans: CT, CAT, MRI, PET etc.	Non-Hospital - 0% after deductible is met. Hospital - $75 co-pay	Non-Hospital - 10% after deductible is met. Hospital - $75 co-pay	Non-Hospital - 20% after deductible is met. Hospital - $75 co-pay	Non-Hospital - 20% after deductible is met. Hospital - $75 co-pay	Non-Hospital - 10% after deductible is met. Hospital - $75 co-pay	30% after deductible
Diagnostic X-ray & Laboratory Procedures	Non-Hospital - 0% after deductible Hospital - $50 co-pay	Non-Hospital - 10% after deductible Hospital - $50 co-pay	Non-Hospital - 20% after deductible Hospital - $50 co-pay	Non-Hospital - 20% after deductible Hospital - $50 co-pay	Non-Hospital - 10% after deductible Hospital - $50 co-pay	30% after deductible
Infertility *(diagnosis/treatment of causes of infertility subject to plan benefits)*	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Care *(includes physical exams & screenings)*	0%	0%	0%	0%	0%	$0
HOSPITAL & SKILLED NURSING FACILITY SERVICES						
Emergency Room (ER) visit **Co-pay waived if admitted as in- patient*	$100 ER co-pay $175 Non-ER co-pay 0% paid after deductible	$100 ER co-pay $175 Non-ER co-pay 10% paid after deductible	$100 ER co-pay $175 Non-ER co-pay 20% paid after deductible	$100 ER co-pay $175 Non-ER co-pay 20% paid after deductible	$100 ER co-pay $175 Non-ER co-pay 10% paid after deductible	Deductible $250 co-pay
Inpatient Hospital (preauthorization required) - limits may apply	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% After deductible
Outpatient Hospital	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% After deductible
Surgery, Outpatient (performed in Surgery Center)	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% After deductible
Surgery, Outpatient (performed in a Hospital) - limits may apply	$250	$250 then 10% after deductible	$250 then 20% after deductible	$250 then 20% after deductible	$250 then 10% after deductible	30% After deductible
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT						
INPATIENT: Facility Based Care (pre-auth required)	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% After deductible
OUTPATIENT: Facility Based Care (pre-auth required)	$20	$30	$20	$30	$20	First 3 $60 Ded. Waived, then 30% after Ded.
OTHER SERVICES						
Acupuncture - Limits apply	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% after deductible
Ambulance (Ground or Air)	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% after deductible
Chiropractic - Limits apply	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% after deductible
Durable Medical Equipment (DME)	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% after deductible
Physical and Occupational Therapy - Limits apply	0%	10% after deductible	20% after deductible	20% after deductible	10% after deductible	30% after deductible

*** This summary represents a high-level overview of the District medical plans for the 2021-2022 plan year. For detailed information, please refer to the plan-specific SBC (Summary of Benefits and Coverage) or SPD (Summary Plan Description).*

2021-2022 Health Benefits Summary

2021-2022 Plan Benefits	CVT Blue Shield PPO 2B	CVT Blue Shield PPO 5B	CVT Blue Shield PPO 6B	CVT Blue Shield PPO 8B	CVT Blue Shield PPO Wellness 1	CVT Blue Shield PPO BRONZE
	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
PHARMACY BENEFITS						
Plan	**Rx B**	**Rx B**	**Rx B**	**Rx B**	**Wellness Rx**	**Bronze Rx**
Generic co-pay/30 days supply	$7	$7	$7	$7	$7	$25 after Ded
Brand co-pay/30 days supply	$15	$15	$15	$15	$25	$50 after Ded
Non-Preferred Brand co-pay 30 days	$30	$30	$30	$30	$40	$50 after Ded
Specialty co-pay/up to 30 days supply	$30	$30	$30	$30	$40	$50 after Ded
Mail Order Pharmacy	CVS	CVS	CVS	CVS	CVS	CVS
Mail Order (Generic-Brand-Non-Preferred Brand co-pay/90 days supply)	$15-$35-$70	$15-$35-$70	$15-$35-$70	$15-$35-$70	$15-$60-$90	$50-$100-$100 after Ded

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Delta Dental

In this incentive plan, Delta Dental pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Consecutive years you are covered by the incentive plan	First year	Second year	Third year	Fourth year
Your plan pays	70%	80%	90%	100%
Your coinsurance	30%	20%	10%	None[2]

***Note: This is a partial summary of Delta Dental Benefits. Please contact Delta Dental at 800.499.3001 or visit www.deltadentalins.com for detailed information.*

VSP Vision

	IN-NETWORK	OUT-OF NETWORK
Exam	No Charge	Up to $45
Frames	• $120 allowance • $140 for featured frame brands • 20% savings on amount over allowance	Up to $47
Single-Lenses	No Charge	Up to $45
Bi-Focal Lenses	No Charge	Up to $65
Tri-Focal Lenses	No Charge	Up to $85
Benefit Frequency for Exam, Contacts/ Lenses, Frames	Once every 12 months	Once every 12 months

***Note: This is a partial summary of VSP Vision Benefits. Please contact VSP at 800.877.7195 or visit www.vsp.com for detailed information.*

Active GTA - CVT: Medical, Vision & Dental Rates

2021/2022 (October 2021 - September 2022) Plans PPO- 2B, 5B, 6B, 8B, Wellness 1, Bronze 60 with Dental and Vision

CERTIFICATED CAP RATES				EMPLOYEE DEDUCTION AMOUNTS
MEDICAL	**PLAN**	**2021/2022 PREMIUM**	**CAP**	**12 MO**
Employee Only	PPO-2B	$792.00	$554.52	$237.48
Employee + Spouse	PPO-2B	$1,665.00	$816.74	$848.26
Employee + Child(ren)	PPO-2B	$1,505.00	$1,117.25	$387.75
Family	PPO-2B	$2,535.00	$1,117.25	$1,417.75
Employee Only	PPO-5B	$730.00	$554.52	$175.48
Employee + Spouse	PPO-5B	$1,535.00	$816.74	$718.26
Employee + Child(ren)	PPO-5B	$1,388.00	$1,117.25	$270.75
Family	PPO-5B	$2,338.00	$1,117.25	$1,220.75
Employee Only	PPO-6B	$679.00	$554.52	$124.48
Employee + Spouse	PPO-6B	$1,427.00	$816.74	$610.26
Employee + Child(ren)	PPO-6B	$1,290.00	$1,117.25	$172.75
Family	PPO-6B	$2,173.00	$1,117.25	$1,055.75
Employee Only	PPO-8B	$614.00	$554.52	$59.48
Employee + Spouse	PPO-8B	$1,291.00	$816.74	$474.26
Employee + Child(ren)	PPO-8B	$1,167.00	$1,117.25	$49.75
Family	PPO-8B	$1,966.00	$1,117.25	$848.75
Employee Only	Wellness 1	$690.00	$554.52	$135.48
Employee + Spouse	Wellness 1	$1,448.00	$816.74	$631.26
Employee + Child(ren)	Wellness 1	$1,311.00	$1,117.25	$193.75
Family	Wellness 1	$2,206.00	$1,117.25	$1,088.75
Employee Only	Bronze 60	$382.00	$554.52	$0.00
Employee + Spouse	Bronze 60	$803.00	$816.74	$0.00
Employee + Child(ren)	Bronze 60	$726.00	$1,117.25	$0.00
Family	Bronze 60	$1,222.00	$1,117.25	$104.75
DENTAL				
Employee Only	HIGH W/ORTHO	$44.90	$49.62	$0.00
Employee + 1	HIGH W/ORTHO	$82.60	$92.50	$0.00
Family	HIGH W/ORTHO	$143.70	$159.91	$0.00
VISION				
Employee Only	B/10	$10.20	$11.70	$0.00
Employee + 1	B/10	$15.20	$16.61	$0.00
Family	B/10	$25.40	$29.63	$0.00