$1,000 Deductible Medical Plan

2017 PREMIUM RATES	
Employee Incentive = Premium if Employee & Spouse participated in 2016 Health Screening	15% of Premium Rate Single = Family =
Employee Monthly Contribution	20% of Premium Rate Single = Family =

HEALTH REIMBURSEMENT ACCOUNT:

No employer funding 2017. Anyone with positive account balances will carry over into 2017. Anyone with positive balances into 2018 will be charged the HRA monthly administrative fee.

VT Teamster HRA:
HRA funding will follow contract provisions.

90 Day retail—Please contact doctor's office in 2017 to resend prescription to allow to be dispensed in 90 day supply quantity.

Types of Coverage	$1,000 Deductible Plan Network Benefits/ Copayment Amounts	$1,000 Deductible Plan Non-Network Benefits/ Copayment Amounts
Annual Deductible Individual Family	 $1,000 $2,000	 $2,000 $4,000
Out-of-Pocket Maximum (includes the deductible) **Individual** **Family**	 $3,100 $6,200 All medical & RX copays apply to OOP max	 $6,200 $12,400 All medical & RX copays apply to OOP max
Lifetime Maximum	None	None
Coinsurance	10%	30%
Doctor Office Visits	$25 copay per visit	30% after deductible
Specialist Office Visit	$40 copay per visit	30% after deductible
Inpatient Hospital	10% after deductible	30% after deductible
Outpatient Surgery	10% after deductible	30% after deductible
Emergency Room Care	$100 copay, remaining balance 10% after deductible	$100 copay, remaining balance 10% after deductible
Urgent Care	$50 copay per visit	30% after deductible
Outpatient Diagnostic Services	10% after deductible	30% after deductible
CT scans, MRI, PET scans and Nuclear Medicine	10% after deductible	30% after deductible
Preventive Care - following federal guidelines	100%	30% after deductible
Eligibility Definition	Domestic Partner eligibility is eliminated on all plans. Only legally married spouses are allowed on plan as of 1/1/17.	
Diabetic Supplies (non pharmacy)	10% after deductible	30% after deductible
Surgical procedures performed in doctor's office	10% after deductible	30% after deductible
Non preventive Mammography & scopic procedures	10% after deductible	30% after deductible
Allergy injections	10% (no deductible applied)	30% after deductible
Facility Charge	Allow facility charge included in "specialist copay"	30% after deductible
Transplant Services	10% after deductible - Mandatory to use UHC Centers of Excellence	not covered
Prescription Drug Coverage Participating Providers Only	31 Day Supply Retail Tier 1 - $10 copay Tier 2 - 25 Copay Tier 3 - $50 copay	90 day retail & mail order Tier 1 $30 copay Tier 2 $75 copay Tier 3 $150 copay Add in 90 day supply available at retail pharmacy as of 1/1/17.

$1,500/$3,000 HIGH DEDUCTIBLE HEALTH PLAN

2017 Premium Rates	
Employee Incentive = Premium if Employee & Spouse participated in 2016 Health Screening	$0
Employee Monthly Contribution	5% of premium Single = $ Family = $

90 Day retail—Please contact doctor's office in 2017 to resend prescription to allow to be dispensed in 90 day supply quantity.

PLAN INFORMATION:
Claims Administrator
United HealthCare
PO Box 30555
Salt Lake City, UT 84130
1-800-868-9532

	$1,500/$3,000 Deductible Plan	
Types of Coverage	Network Benefits/ Copayment Amounts	Non-Network Benefits/ Copayment Amounts
Annual Deductible Individual Family	 $1,500 $3,000	 $2,500 $5,000
Out-of-Pocket Maximum (includes the deductible) **Individual** **Family**	 $3,000 $6,000	 $5,000 $10,000
Lifetime Maximum	None	None
Coinsurance	10%	30%
Doctor Office Visits	10% after deductible	30% after deductible
Specialist Office Visit	10% after deductible	30% after deductible
Inpatient Hospital	10% after deductible	30% after deductible
Outpatient Surgery	10% after deductible	30% after deductible
Emergency Room Care	10% after deductible	30% after deductible
Urgent Care	10% after deductible	30% after deductible
Outpatient Diagnostic Services	10% after deductible	30% after deductible
CT scans, MRI, PET scans and Nuclear Medicine	10% after deductible	30% after deductible
Preventive Care - following federal guidelines	100%	30% after deductible
Eligibility Definition	Domestic Partner eligibility is eliminated on all plans. Only legally married spouses are allowed on plan as of 1/1/17.	
Diabetic Supplies (non pharmacy)	10% after deductible	30% after deductible
Surgical procedures performed in doctor's office	10% after deductible	30% after deductible
Non preventive Mammography & scopic procedures	10% after deductible	30% after deductible
Allergy injections	10% after deductible	30% after deductible
Facility Charge	10% after deductible	30% after deductible
Transplant Services	10% after deductible - Mandatory to use UHC Centers of Excellence	not covered
Prescription Drug Coverage Participating Providers Only	All drugs will apply to the deductible. Once satisfied, the 3 tier copays will apply. Any drugs listed on UHC Chronic Conditions listing will be considered preventive and covered at 100%	RX Preventive drug listing for 2017 is located on the city's website. Add in 90 day supply available at retail pharmacy as of 1/1/17.

DENTAL INSURANCE

Non –Union, Police & Fire - no changes to the listed below dental coverage for 2017
Valley Transit Teamster—Dental coverage changing to coverage listed below effective 1/1/17

EMPLOYEE PREMIUMS:
Single: $10 per month
Family: $20 per month

HOW TO FIND A PROVIDER

On the Web:
Go to www.deltadentawi.com and click the "Dentist Search" link. You will be directed to the "Find a Network Dentist in your Area" page.

By Phone:
To access Delta's dentist directories, call 800-236-3712 and follow the automated instructions. Participating dentists can be searched by ZIP code.

If you choose to use a dentist that is not a Delta Dental provider, please make sure that the charges are within Delta's usual and customary charges or you may be responsible for the amount over the allowed amount.

PLAN INFORMATION:
Claims Administrator:
Delta Dental of Wisconsin
PO Box 828
Stevens Point, WI 54481
800-236-3712

DELTA DENTAL

Your Dental Benefits

The summary below does not cover all plan details. Further information can be found in the summary plan description or dental benefit handbook. That document provides a thorough explanation of your dental plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

BENEFIT PLAN DESIGN		Delta Dental
Individual Annual Maximum		$1,500
Individual Oral Surgery Annual Maximum*		$2,000
Deductible	Individual	$50
	Family	$150
Dependent Eligibility		
Dependents are eligible through the end of the year in which they attain age 26, except as noted for orthodontics		
Diagnostic & Preventive Services		
Exams		100%
Cleanings		100%
Fluoride Treatments		100%
X-rays		100%
Sealants		100%
Space maintainers		100%
	Deductible applies	No
Basic & Major Services (Applies to Individual Annual Maximum)		
Emergency treatment to relieve pain		80%
Fillings		80%
Extractions - nonsurgical		80%
Endodontics-nonsurgical		50%
Endodontics-surgical		50%
Periodontics-nonsurgical		50%
Periodontics-surgical		50%
Crowns, inlays, onlays		50%
Bridges and dentures		50%
Implants - nonsurgical		50%
	Deductible applies	Yes
Major Services (Applies to Individual Oral Surgery Annual Maximum)		
Extractions - surgical and other oral surgery		50%
Implants-surgical		50%
	Deductible applies	Yes
Orthodontic Services		
Coverage copayment		50%
Individual lifetime maximum		$2,500
Dependents eligible to age		19
Adult ortho		Yes
	Deductible applies	No
Special Plan Provisions		
Evidence-Based Integrated Care Plan		Yes
CheckUp Plus		Yes