# EVERETT PUBLIC SCHOOL 2016 COMPARISON OF PLANS

***January 2016 - December 2016***
***Summary of Covered Medical Benefits***
***Benefits subject to calendar year deductible, unless noted otherwise.***

| Benefit | Group Health Cooperative (HMO) | UHC Option 4 (Previously Easy Choice A) | UHC Option 5 (Previously Easy Choice B) | UHC Option 6 (Previously Easy Choice C) | UHC Option 3 (Previously WEA Plan 3) | UHC Option 2 (Previously WEA Plan 2) | UHC Option 1 (Previously WEA Plan 5) | UHC HDHP Option 7 (Previously WEA QHDHP) |
|---|---|---|---|---|---|---|---|---|
| **Choice of Providers** | Choose a GH family practice provider at GH Medical Centers or at a contracted GH medical center. You may self-refer to most GH specialists at Group Health owned or operated medical centers. Referrals to non-GH contracted specialists must be obtained through your regular physician. Contact Group Health for details. | UnitedHealthcare Network | UnitedHealthcare Network | UnitedHealthcare Network | UnitedHealthcare Network | UnitedHealthcare Network | UnitedHealthcare Network | UnitedHealthcare Network |
| **Out-of-Area Benefits** | Emergency care at non-GH-designated facilities subject to $100 copay per emergency. If admitted directly from the emergency room, the $100 copay is waived, and requires notification to GH within 24 hours of admission. | For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims. | For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims. | For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims. | For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims. | For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims. | For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims. | For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims. |
| **Calendar Year Deductible** | None | **In-Network**: $1,000 per person or $3,000 per family **Out-of-Network**: $2,000 per person or $6,000 per family (waived for office visits and in-network preventive care) There is a separate deductible for prescription drugs | **In-Network**: $750 per person or $2,250 per family **Out-of-Network**: $1,500 per person or $4,500 per family (waived for office visits and in-network preventive care) There is a separate deductible for prescription drugs | **In-Network**: $100 per person or $300 per family **Out-of-Network**: $250 per person or $750 per family (waived for office visits and in-network preventive care) There is a separate deductible for prescription drugs | **Combined in-network and out-of-network:** $300 per person or $900 per family (waived for office visits, in-network preventive care and prescription drugs) | **Combined in-network and out-of-network:** $200 per person or $600 per family (waived for office visits, in-network preventive care and prescription drugs) | **In-Network:** $200 per person or $600 per family **Out-of-Network:** $350 per person (waived for office visits, in-network preventive care and prescription drugs) | **In-Network:** $1,500 individual or $3,000 family **Out-of-Network:** $3,000 individual or $6,000 family (waived for in-network preventive care) |
| **Coinsurance** | No plan coinsurance | **In-Network:** 80% **Out-of-Network:** 50% | **In-Network:** 75% **Out-of-Network:** 50% | **In-Network:** 65% **Out-of-Network:** 50% | **In-Network:** 80% **Out-of-Network:** 60% | **In-Network:** 80% **Out-of-Network:** 60% | **In-Network:** 90% **Out-of-Network:** 70% | **In-Network:** 80% **Out-of-Network:** 50% |
| **Annual Out-of-Pocket Maximum** | $2,000/person; $4,000/family. | **In-Network**: $4,000 per person or $12,000 per family (includes deductible, coinsurance and copays) **Out-of-Network:** Unlimited | **In-Network**: $3,500 per person or $10,500 per family (includes deductible, coinsurance and copays) **Out-of-Network:** Unlimited | **In-Network**: $4,200 per person or $12,600 per family (includes deductible, coinsurance and copays) **Out-of-Network:** Unlimited | **Combined in-network and out-of-network:** $2,750 per person or $8,250 per family (includes deductible, coinsurance and copays) | **Combined in-network and out-of-network:** $1,500 per person or $4,500 per family (includes deductible, coinsurance and copays) | **In-Network**: $500 per person/$1,500 family (includes deductible, coinsurance and copays) **Out-of-Network:** Unlimited | **In-Network**: $4,000 individual or $8,000 family (includes deductible, coinsurance and copays) **Out-of-Network:** Unlimited |
| **Lifetime Maximum** | None | None | None | None | None | None | None | None |
| **Office Visit Copays / Coinsurance** | Your copay for most office visits is $15/visit. | **In-Network:** $15 **Out-of-Network:** 50% | **In-Network:** $30 **Out-of-Network:** 50% | **In-Network:** $35 **Out-of-Network:** 50% | **In-Network:** $30 **Out-of-Network:** $40 | **In-Network:** $25 **Out-of-Network:** $30 | **In-Network:** $15 **Out-of-Network:** 70% | **In-Network:** 80% **Out-of-Network:** 50% |
| **Preexisting Conditions** | None | None | None | None | None | None | None | None |

**Questions about covered expenses? Limitations? List of providers? Call the plan or check their website.**

**Group Health Cooperative HMO (Group # 00261000):** Customer Service: 1-888-901-4636, between 8:00 a.m. and 5:00 p.m. (Pacific) Monday-Friday, www.ghc.org

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| **UHC Customer Service (Group 0903108):** | Options 1, 2, 3, 4, 5, 6: 1-866-633-2446, HDHP Option 7: 1-866-314-0335, www.myuhc.com/member |
|---|---|

## EVERETT PUBLIC SCHOOL 2016 COMPARISON OF PLANS

| ***Summary of Covered Medical Benefits***<br>***Benefits subject to calendar year deductible, unless noted otherwise.*** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Group Health Cooperative (HMO)** | **UHC Option 4 (Previously Easy Choice A)** | **UHC Option 5 (Previously Easy Choice B)** | **UHC Option 6 (Previously Easy Choice C)** | **UHC Option 3 (Previously WEA Plan 3)** | **UHC Option 2 (Previously WEA Plan 2)** | **UHC Option 1 (Previously WEA Plan 5)** | **UHC HDHP Option 7 (Previously WEA QHDHP)** |
| **Alternative Care** | Acupuncture: Self-referral up to 8 visits per condition/calendar year subject to a $15 copay per visit.<br><br>GHC contracted providers only | Acupuncture: Limited to 12 visits per calendar year<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network**: 50% | Acupuncture: Limited to 12 visits per calendar year<br>**In-Network:** $30, not subject to deductible<br>**Out-of-Network:** 50% | Acupuncture: Limited to 12 visits per calendar year<br>**In-Network**: $35, not subject to deductible<br>**Out-of-Network:** 50% | Acupuncture: Limited to 12 visits per calendar year, not subject to deductible<br>**In-Network:** $30<br>**Out-of-Network:** $40 | Acupuncture: Limited to 12 visits per calendar year, not subject to deductible<br>**In-Network:** $25<br>**Out-of-Network:** $30 | Acupuncture: Unlimited;<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 70% | Acupuncture: Limited to 12 visits per calendar year<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |
| | Naturopathy: Self-referral up to 3 visits per condition/calendar year subject to a $15 copay per visit.<br><br>GHC contracted providers only | Naturopathy: Unlimited<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 50% | Naturopathy: Unlimited<br>**In-Network:** $30, not subject to deductible<br>**Out-of-Network**: 50% | Naturopathy: Unlimited<br>**In-Network**: $35, not subject to deductible<br>**Out-of-Network:** 50% | Naturopathy: Unlimited, not subject to deductible<br>**In-Network:** $30<br>**Out-of-Network:** $40 | Naturopathy: Unlimited, not subject to deductible<br>**In-Network:** $25<br>**Out-of-Network:** $30 | Naturopathy: Unlimited<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 70% | Naturopathy: Unlimited<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Ambulance** | 80% for emergency ground/air transport and for nonemergency ground/air interfacility transfers; 100% for hospital to hospital ground transfers. | 80% | 75% | 65% | 80% | 80% | $50 copay after deductible | 80% |
| **Diagnostic X-ray & Lab** | 100%. | **In-Network:** Not subject to deductible.<br>Minor diagnostic: 100%<br>Major diagnostic: 80%<br>**Out-of-Network**: 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network**: 50% |
| **Durable Medical Equipment** | 80%. | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network**: 50% |
| **Emergency Room** | Emergency room care at GH-designated facilities subject to a $100 copay/visit. Copay is waived if admitted directly to the hospital from the emergency department. Emergency care at non-GH-designated facilities subject to a $100 copay (waived if admitted); if admitted, requires notification to GH within 24 hours of admission. | $100 copay; waived if admitted<br><br>**In-Network:** 80%<br>**Out-of-Network:** 80%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $150 copay; waived if admitted<br><br>**In-Network:** 75%<br>**Out-of-Network:**75%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $200 copay; waived if admitted<br><br>**In-Network:** 65%<br>**Out-of-Network:** 65%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $100 copay; waived if admitted<br><br>**In-Network**: 80%<br>**Out-of-Network:**80%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $75 copay; waived if admitted<br><br>**In-Network:** 80%<br>**Out-of-Network:** 80%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $50 copay; waived if admitted<br><br>**In-Network**: 90%<br>**Out-of-Network:** 90%<br><br>(medical emergencies are always paid at the in-network benefit levels) | **In-Network**: 80%<br>**Out-of-Network:** 80%<br><br>(medical emergencies are always paid at the in-network benefit levels) |

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| **Benefit** | **Group Health Cooperative (HMO)** | **UHC Option 4 (Previously Easy Choice A)** | **UHC Option 5 (Previously Easy Choice B)** | **UHC Option 6 (Previously Easy Choice C)** | **UHC Option 3 (Previously WEA Plan 3)** | **UHC Option 2 (Previously WEA Plan 2)** | **UHC Option 1 (Previously WEA Plan 5)** | **UHC HDHP Option 7 (Previously WEA QHDHP)** |
| **Durable Medical Equipment** | 80%. | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network**: 50% |
| **Emergency Room** | Emergency room care at GH-designated facilities subject to a $100 copay/visit. Copay is waived if admitted directly to the hospital from the emergency department. Emergency care at non-GH-designated facilities subject to a $100 copay (waived if admitted); if admitted, requires notification to GH within 24 hours of admission. | $100 copay; waived if admitted<br><br>**In-Network:** 80%<br>**Out-of-Network:** 80%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $150 copay; waived if admitted<br><br>**In-Network:** 75%<br>**Out-of-Network:**75%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $200 copay; waived if admitted<br><br>**In-Network:** 65%<br>**Out-of-Network:** 65%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $100 copay; waived if admitted<br><br>**In-Network:** 80%<br>**Out-of-Network:**80%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $75 copay; waived if admitted<br><br>**In-Network:** 80%<br>**Out-of-Network:** 80%<br><br>(medical emergencies are always paid at the in-network benefit levels) | $50 copay; waived if admitted<br><br>**In-Network**: 90%<br>**Out-of-Network:** 90%<br><br>(medical emergencies are always paid at the in-network benefit levels) | **In-Network**: 80%<br>**Out-of-Network:** 80%<br><br>(medical emergencies are always paid at the in-network benefit levels) |
| **Skilled Nursing Facility** | 100% up to 60 days/calendar year.<br><br>Services must be medically necessary and authorized in advance by a GH provider. | Up to 30 days per calendar year<br><br>**In-Network:** 80%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Up to 60 days per calendar year<br><br>**In-Network:** 75%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Up to 60 days per calendar year<br><br>**In-Network:** 65%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Up to 130 days per calendar year<br><br>**In-Network:** 80%<br>**Out-of-Network**: not covered<br>(custodial care not covered) | Unlimited<br><br>**In-Network:** 100%<br>**Out-of-Network:** not covered<br>(custodial care not covered) | Up to 60 days per calendar year<br><br>**In-Network: 9**0%<br>**Out-of-Network:** 70%<br><br>(custodial care not covered) | Up to 60 days per calendar year<br><br>**In-Network: 8**0%<br>**Out-of-Network: 5**0%<br><br>(custodial care not covered) |
| **Hearing Care — Exam & Hardware** | Hearing exam: 100% after $15 copay/visit.<br><br>Hearing aids not covered. | One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years.<br>**In-Network:** 80%<br>**Out-of-Network:** 50% | One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years.<br>**In-Network:** 75%<br>**Out-of-Network:** 50% | One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years.<br>**In-Network:** 100%<br>**Out-of-Network:** Not Covered | One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years.<br>**In-Network:** 80%<br>**Out-of-Network:** 60% | One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years.<br>**In-Network:** 80%<br>**Out-of-Network:** 60% | One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years.<br>**In-Network:** 90%<br>**Out-of-Network:** 70% | One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years.<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Home Health Care** | 100% when authorized. | Limited to 130 visits per calendar year<br>**In-Network:** 80%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Limited to 130 visits per calendar year<br>**In-Network**: 75%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Limited to 130 visits per calendar year<br>**In-Network**: 65%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Unlimited; subject to deductible<br>**In-Network:** 80%<br>**Out-of-Network:** 60%<br><br>(custodial care not covered) | Unlimited; subject to deductible<br><br>(custodial care not covered) | Limited to 130 visits per calendar year<br>**In-Network:** 90%<br>**Out-of-Network**: 70%<br><br>(custodial care not covered) | Limited to 130 visits per calendar year<br>**In-Network:** 80%<br>**Out-of-Network**: 50%<br><br>(custodial care not covered) |
| **Hospice Care** | 100% when authorized and provided/coordinated through GH hospice program or GH-approved hospice program. | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | Subject to deductible | Subject to deductible | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |

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|---|---|---|---|---|---|---|---|---|
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| **Home Health Care** | 100% when authorized. | Limited to 130 visits per calendar year<br>**In-Network:** 80%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Limited to 130 visits per calendar year<br>**In-Network**: 75%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Limited to 130 visits per calendar year<br>**In-Network**: 65%<br>**Out-of-Network:** 50%<br><br>(custodial care not covered) | Unlimited; subject to deductible<br>**In-Network:** 80%<br>**Out-of-Network:** 60%<br><br>(custodial care not covered) | Unlimited; subject to deductible<br><br>(custodial care not covered) | Limited to 130 visits per calendar year<br>**In-Network:** 90%<br>**Out-of-Network**: 70%<br><br>(custodial care not covered) | Limited to 130 visits per calendar year<br>**In-Network:** 80%<br>**Out-of-Network**: 50%<br><br>(custodial care not covered) |
| **Hospice Care** | 100% when authorized and provided/coordinated through GH hospice program or GH-approved hospice program. | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | Subject to deductible | Subject to deductible | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Hospital** | | | | | | | | |
| **Inpatient Room & Board** | 100% after $100 copay/day to a maximum of $300 per admission. | **In-Network:** 80%<br>**Out-of-Network: 50%** | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network: 50%** | **In-Network:** 80%<br>$300 copay per admission<br><br>**Out-of-Network:** 60% | **In-Network:** 80%<br>$150 copay per admission<br><br>**Out-of-Network:** 60% | **In-Network:** 90%<br>$200 copay per admission<br><br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network: 5**0% |
| **Outpatient Surgery** | 100% after $15 copay/visit. | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>$150 outpatient surgery copay<br><br>**Out-of-Network**: 60% | **In-Network:** 80%<br>$100 outpatient surgery copay<br><br>**Out-of-Network:** 60% | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Manipulative Treatments (Chiropractic Care)** | Self-referrals for manipulative therapy of spine by GH contracted providers covered up to 10 visits per calendar year, at 100% after $15 copay. | Limited to 12 visits per calendar year<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 50% | Limited to 12 visits per calendar year<br>**In-Network:** $30, not subject to deductible<br>**Out-of-Network:** 50% | Limited to 12 visits per calendar year<br>**In-Network:** $35, not subject to deductible<br>**Out-of-Network:** 50% | Unlimited, not subject to deductible<br>**In-Network:** $30<br>**Out-of-Network:** $40 | Unlimited, not subject to deductible<br>**In-Network:** $25<br>**Out-of-Network:** $30 | Unlimited<br><br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 70% | Limited to 12 visits per calendar year<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |

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|---|---|---|---|---|---|---|---|---|
| **Maternity**<br>**Physician Office Services** | Prenatal/postpartum outpatient visits, covered at 100% after $15 copay for first visit only. | **In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 50%<br><br>For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit. | **In-Network:** $30, not subject to deductible<br>**Out-of-Network:** 50%<br><br>For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit. | **In-Network:** $35, not subject to deductible<br>**Out-of-Network:** 50%<br><br>For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit. | **In-Network:** $30, not subject to deductible<br>**Out-of-Network:** $40<br><br>For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit. | **In-Network:** $25, not subject to deductible<br>**Out-of-Network**: $30<br><br>For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit. | **In-Network:** $15, not subject to deductible<br>**Out-of-Network**: 70%<br><br>For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit. | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Diagnostic X-ray & Lab** | Covered in full | **In-Network:** 100%, not subject to deductible<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Hospital Inpatient Stay (Any applicable cost share for newborn services is separate from that of the mother)** | $100 copay, per day for up to 3 days per admit for inpatient stay. | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>$300 copay per admission<br><br>**Out-of-Network:** 60% | **In-Network:** 80%<br>$150 copay per admission<br><br>**Out-of-Network:** 60% | **In-Network:** 90%<br>$200 copay per admission<br><br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Physicians Fees for Surgical and Medical Services** | Subject to hospital copay | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>**Out-of-Network**: 60% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Mental Health Care**<br>**Inpatient** | Inpatient: subject to inpatient cost share when authorized in advance by GH for treatment in a GH-approved facility. | Inpatient:<br>**In-Network:** 80%<br>**Out-of-Network:** 50% | Inpatient:<br>**In-Network:** 75%<br>**Out-of-Network:** 50% | Inpatient:<br>**In-Network:** 65%<br>**Out-of-Network:** 50% | Inpatient:<br>**In-Network:** 80%<br>subject to inpatient hospital copay<br><br>**Out-of-Network:** 60% | Inpatient:<br>**In-Network:** 80%<br>subject to inpatient hospital copay<br><br>**Out-of-Network:** 60% | Inpatient:<br>**In-Network:** 90%<br>subject to inpatient hospital copay<br><br>**Out-of-Network:** 70% | Inpatient:<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Outpatient** | Outpatient: 100% after $15 copay/visit. | Outpatient:<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 50% | Outpatient:<br>**In-Network:** $30, not subject to deductible<br>**Out-of-Network**: 50% | Outpatient:<br>**In-Network:** $35, not subject to deductible<br>**Out-of-Network:** 50% | Outpatient: not subject to deductible<br>**In-Network:** $30<br>**Out-of-Network:** $40 | Outpatient: not subject to deductible<br>**In-Network:** $25<br>**Out-of-Network:** $30 | Outpatient:<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 70% | Outpatient:<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Orthotics** | Not covered. | Up to $300 per calendar year<br>**In-Network:** 80%<br>**Out-of-Network:** 50% | Up to $300 per calendar year<br>**In-Network:** 75%<br>**Out-of-Network**: 50% | Up to $300 per calendar year<br>**In-Network:** 65%<br>**Out-of-Network:** 50% | Up to $600 per calendar year<br>**In-Network:** 80%<br>**Out-of-Network:** 60% | Up to $600 per calendar year<br>**In-Network:** 80%<br>**Out-of-Network:** 60% | Up to $600 per calendar year<br>**In-Network:** 90%<br>**Out-of-Network:** 70% | Up to $300 per calendar year<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |

# EVERETT PUBLIC SCHOOL 2016 COMPARISON OF PLANS

| ***Summary of Covered Medical Benefits*** ***Benefits subject to calendar year deductible, unless noted otherwise.*** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Group Health Cooperative (HMO)** | **UHC Option 4 (Previously Easy Choice A)** | **UHC Option 5 (Previously Easy Choice B)** | **UHC Option 6 (Previously Easy Choice C)** | **UHC Option 3 (Previously WEA Plan 3)** | **UHC Option 2 (Previously WEA Plan 2)** | **UHC Option 1 (Previously WEA Plan 5)** | **UHC HDHP Option 7 (Previously WEA QHDHP)** |
| **Physician Visits** | | | | | | | | |
| **Office, Clinic or Home** | 100% after $15 copay/visit. Home calls covered within GH service area when prescribed as medically necessary by a GH provider. | Office, clinic or home visit: **In-Network:** $15, not subject to deductible **Out-of-Network**: 50% | Office, clinic or home visit: **In-Network:** $30, not subject to deductible **Out-of-Network**: 50% | Office, clinic or home visit: **In-Network:** $35, not subject to deductible **Out-of-Network**: 50% | Office, clinic or home visit: not subject to deductible **In-Network:** $30 **Out-of-Network:** $40 | Office, clinic or home visit: not subject to deductible **In-Network:** $25 **Out-of-Network:** $30 | Office, clinic or home visit: **In-Network:** $15, not subject to deductible **Out-of-Network:** 70% | Office, clinic or home visit: **In-Network:** 80% **Out-of-Network:** 50% |
| **Hospital Outpatient Physician Visit** | | Hospital outpatient physician visit: **In-Network**: 80% **Out-of-Network:** 50% | Hospital outpatient physician visit: **In-Network:** 75% **Out-of-Network:** 50% | Hospital outpatient physician visit: **In-Network:** 65% **Out-of-Network:** 50% | Hospital outpatient physician visit: **In-Network:** 80% **Out-of-Network:** 60% | Hospital outpatient physician visit: **In-Network:** 80% **Out-of-Network:** 60% | Hospital outpatient physician visit: **In-Network:** 90% **Out-of-Network:** 70% | Hospital outpatient physician visit: **In-Network:** 80% **Out-of-Network:** 50% |
| **Hospital Inpatient** | Subject to inpatient hospital cost share. | **In-Network:** 80% **Out-of-Network:** 50% | **In-Network:** 75% **Out-of-Network:** 50% | **In-Network:** 65% **Out-of-Network:** 50% | **In-Network:** 80% **Out-of-Network:** 60% | **In-Network:** 80% **Out-of-Network:** 60% | **In-Network:** 90% **Out-of-Network:** 70% | **In-Network:** 80% **Out-of-Network:** 50% |
| **Prescription Drugs** | 100% after $10 (generic) and $20 (brand) copay for each 30-day supply or less. Non-formulary drugs are not covered. | Retail: Up to a 31 day supply; Tier 1 - $0 Tier 2 - 30% Tier 3 - 30% | Retail: Up to a 31 day supply; Tier 1 - $0 Tier 2 - $30 Tier 3 - $45 | Retail: Up to a 31 day supply; Tier 1 - $0 Tier 2 - $30 Tier 3 - $45 | Retail: Up to a 31 day supply; Tier 1 - $15 Tier 2 - $25 Tier 3 - $40 | Retail: Up to a 31 day supply; Tier 1 - $10 Tier 2 - $20 Tier 3 - $35 | Retail: Up to a 31 day supply; Tier 1 - $10 Tier 2 - $15 Tier 3 - $30 | Retail: Up to a 31 day supply; 80% coinsurance |
| | Mail order: 100% after $20 (generic) and $40 (brand) copay for each 90-day supply. | Mail order: Up to a 90 day supply; Tier 1 - $0 Tier 2 - 25% Tier 3 - 25% | Mail order: Up to a 90 day supply; Tier 1 - $0 Tier 2 - $75 Tier 3 - $112 | Mail order: Up to a 90 day supply; Tier 1 - $0 Tier 2 - $75 Tier 3 - $112 | Mail order: Up to a 90 day supply; Tier 1 - $15 Tier 2 - $25 Tier 3 - $40 | Mail order: Up to a 90 day supply; Tier 1 - $10 Tier 2 - $20 Tier 3 - $35 | Mail order: Up to a 90 day supply; Tier 1 - $10 Tier 2 - $30 Tier 3 - $60 | Mail order: Up to a 90 day supply; 80% coinsurance |
| | | Drug deductible: $500 per person per calendar year; waived for Tier 1 Subject to medical out-of-pocket maximum. | Drug deductible: $250 per person per calendar year; waived for Tier 1 Subject to medical out-of-pocket maximum. | Drug deductible: $500 per person per calendar year; waived for Tier 1 Subject to medical out-of-pocket maximum. | No deductible. Subject to the medical out-of-pocket maximum. | No deductible. Subject to the medical out-of-pocket maximum. | No deductible. Subject to the medical out-of-pocket maximum. | No deductible. Subject to the medical out-of-pocket maximum. |
| | | Specialty drugs: up to 31 day supply subject to Tier 3 cost share. | Specialty drugs: up to 31 day supply subject to Tier 3 cost share. | Specialty drugs: up to 31 day supply subject to Tier 3 cost share. | Specialty drugs: up to 31 day supply subject to Tier 3 cost share. | Specialty drugs: up to 31 day supply subject to Tier 3 cost share. | Specialty drugs: up to 31 day supply subject to Tier 3 cost share. | Specialty drugs: up to 31 day supply subject to Tier 3 cost share. |

This is a brief summary of the plans offered by Everett School District and does not constitute a contract. Please refer to the specific plan booklets for complete information regarding benefits, exclusions and eligibility requirements

# EVERETT PUBLIC SCHOOL 2016 COMPARISON OF PLANS

| Summary of Covered Medical Benefits<br>Benefits subject to calendar year deductible, unless noted otherwise. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Group Health Cooperative (HMO)** | **UHC Option 4 (Previously Easy Choice A)** | **UHC Option 5 (Previously Easy Choice B)** | **UHC Option 6 (Previously Easy Choice C)** | **UHC Option 3 (Previously WEA Plan 3)** | **UHC Option 2 (Previously WEA Plan 2)** | **UHC Option 1 (Previously WEA Plan 5)** | **UHC HDHP Option 7 (Previously WEA QHDHP)** |
| **Rehabilitation (Check benefit booklet for visit limits)** | **Inpatient:**<br>Inpatient physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under, covered to 60 days each calendar year, at 100% after $100 copay/day to a maximum of $300 per admission.<br><br>**Outpatient:**<br>Covered up to 60 visits (combined with speech and occupational therapy) per calendar year, at 100% after $15 copay/visit. | Occupational, speech, massage and physical therapy.<br>30 Massage Visits allowed yearly.<br>30 Physical Therapy visits allowed yearly.<br><br>Subject to deductible.<br><br>**Inpatient:**<br>**In-Network**: 80%<br>**Out-of-Network:** 50%<br><br>**Outpatient:**<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network**: 50% | Occupational, speech, massage and physical therapy.<br>45 Massage Therapy visits yearly.<br>45 Physical Therapy visits yearly.<br><br>Subject to deductible.<br><br>**Inpatient:**<br>**In-Network:** 75%<br>**Out-of-Network:** 50%<br><br>**Outpatient**:<br>**In-Network:** $30, not subject to deductible<br>**Out-of-Network**: 50% | Occupational, speech, massage and physical therapy.<br>45 Massage visits yearly.<br>45 Physical Therapy visits.<br><br>Subject to deductible.<br><br>**Inpatient:**<br>**In-Network:** 65%<br>**Out-of-Network**: 50%<br><br>**Outpatient:**<br>**In-Network:** $35, not subject to deductible<br>**Out-of-Network:** 50% | Occupational, speech and massage therapy.<br>45 Massage Therapy visits yearly.<br>Unlimited Physical Therapy<br><br>Subject to deductible.<br><br>**Inpatient:**<br>**In-Network:** 80%<br>**Out-of-Network:** 60%<br><br>**Outpatient:**<br>**In-Network:** $30<br>**Out-of-Network:** $40 | Occupational, speech and massage therapy.<br>45 Massage Therapy visits yearly.<br>Unlimited Physical Therapy<br><br>Subject to deductible.<br><br>**Inpatient**:<br>**In-Network:** 80%<br>**Out-of-Network:** 60%<br><br>**Outpatient:**<br>**In-Network:** $25<br>**Out-of-Network:** $30 | Occupational, speech, massage and physical therapy.<br>45 Massage Therapy visits yearly.<br>45 Physial Therapy visits yearly.<br><br>Subject to deductible.<br><br>**Inpatient:**<br>**In-Network:** 90%<br>**Out-of-Network:** 70%<br><br>**Outpatient:**<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network**: 70% | Occupational, speech, massage and physical therapy.<br>15 Massage visits allowed yearly.<br>15 Physical Therapy visits allowed yearly.<br><br>Subject to deductible.<br><br>**Inpatient:**<br>**In-Network:** 80%<br>**Out-of-Network:** 50%<br><br>**Outpatient:**<br>**In-Network:** 80%<br>**Out-of-Network**: 50% |
| **Physical Therapy** | See Rehabilitation | See Rehabilitation | See Rehabilitation | See Rehabilitation | **Inpatient:** Limited to 30 days per calendar year; Subject to Inpatient hospital copay<br>**In-Network:** 80%<br>**Out-of-Network:** 60%<br><br>**Outpatient:** Unlimited<br>**In-Network:** 80%<br>**Out-of-Network:** 60% | **Inpatient:** Limited to 120 days per calendar year; Subject to Inpatient hospital copay<br>**In-Network:** 80%<br>**Out-of-Network:** 60%<br><br>**Outpatient:** Unlimited<br>**In-Network:** 80%<br>**Out-of-Network:** 60% | See Rehabilitation | See Rehabilitation |
| **Preventive Care - Exam and Immunizations** | Well-care physicals, immunizations are covered at 100% | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network**: Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network**: Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network**: Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network**: Not covered |
| **Preventive Care - Screenings** | Covered at 100% | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered | Unlimited<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered |

# EVERETT PUBLIC SCHOOL 2016 COMPARISON OF PLANS

| ***Summary of Covered Medical Benefits***<br>***Benefits subject to calendar year deductible, unless noted otherwise.*** | | | | | | | | |
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| **Benefit** | **Group Health Cooperative (HMO)** | **UHC Option 4 (Previously Easy Choice A)** | **UHC Option 5 (Previously Easy Choice B)** | **UHC Option 6 (Previously Easy Choice C)** | **UHC Option 3 (Previously WEA Plan 3)** | **UHC Option 2 (Previously WEA Plan 2)** | **UHC Option 1 (Previously WEA Plan 5)** | **UHC HDHP Option 7 (Previously WEA QHDHP)** |
| **Smoking/Tobacco Cessation** | Approved pharmacy products covered 100% when prescribed and dispensed as part of GHC-designated program. Quit for Life products dispensed through mail order only. | Tobacco cessation programs<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered<br><br>Office visits for Tobacco cessation covered as Preventive Care.<br><br>Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included. | Tobacco cessation programs<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered<br><br>Office visits for Tobacco cessation covered as Preventive Care.<br><br>Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included. | Tobacco cessation programs<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered<br><br>Office visits for Tobacco cessation covered as Preventive Care.<br><br>Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included. | Tobacco cessation programs<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered<br><br>Office visits for Tobacco cessation covered as Preventive Care.<br><br>Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included. | Tobacco cessation programs<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered<br><br>Office visits for Tobacco cessation covered as Preventive Care.<br><br>Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included. | Tobacco cessation programs<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered<br><br>Office visits for Tobacco cessation covered as Preventive Care.<br><br>Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included. | Tobacco cessation programs<br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Not covered<br><br>Office visits for Tobacco cessation covered as Preventive Care.<br><br>Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included. |
| **Substance Abuse Disorder** | Inpatient: 100% after $100 copay/day to a maximum of $300 per admission. | Inpatient:<br>**In-Network**: 80%<br>**Out-of-Network:** 50% | Inpatient:<br>**In-Network**: 75%<br>**Out-of-Network**: 50% | Inpatient:<br>**In-Network:** 65%<br>**Out-of-Network:** 50% | Inpatient:<br>**In-Network:** 80%<br>(subject to inpatient hospital copay)<br><br>**Out-of-Network:** 60% | Inpatient:<br>**In-Network:** 80%<br>(subject to inpatient hospital copay)<br><br>**Out-of-Network:** 60% | Inpatient:<br>**In-Network:** 90%<br>(subject to inpatient hospital copay)<br><br>**Out-of-Network:** 70% | Inpatient:<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |
| | Outpatient: 100% after $15 copay/visit. | Outpatient:<br>**In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 50% | Outpatient:<br>**In-Network:** $30, not subject to deductible<br>**Out-of-Network:** 50% | Outpatient:<br>**In-Network:** $35, not subject to deductible<br>**Out-of-Network:** 50% | Outpatient: not subject to deductible<br>**In-Network:** $30<br>**Out-of-Network:** $40 | Outpatient: not subject to deductible<br>**In-Network:** $25<br>**Out-of-Network:** $30 | Outpatient:<br>**In-Network**: $15, not subject to deductible<br>**Out-of-Network:** 70% | Outpatient:<br>**In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Surgeon Fees** | 100% if provided by a GH provider at a GH facility. | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Temporomandibular Joint Disorder/Maxillofacial Surgery** | 100%** up to $1,000/calendar year; lifetime maximum of $5,000. TMJ appliances: 80%.<br><br>**Inpatient: after $100 copay per day (3 days max)<br>Outpatient: $15 copay | Not covered. | Not covered. | Not covered. | **In-Network:** 50%<br>**Out-of-Network:** 50%<br>Surgical treatment: covered as any other surgery | **In-Network:** 50%<br>**Out-of-Network:** 50%<br>Surgical treatment: covered as any other surgery | **In-Network:** 50%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Therapeutic Treatments - Outpatient** | Outpatient: subject to $15 copay. Therapeutic treatments performed at home, covered in full. | **In-Network:** 80%<br>**Out-of-Network:** 50% | **In-Network:** 75%<br>**Out-of-Network:** 50% | **In-Network:** 65%<br>**Out-of-Network:** 50% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 80%<br>**Out-of-Network:** 60% | **In-Network:** 90%<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |

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|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Group Health Cooperative (HMO)** | **UHC Option 4 (Previously Easy Choice A)** | **UHC Option 5 (Previously Easy Choice B)** | **UHC Option 6 (Previously Easy Choice C)** | **UHC Option 3 (Previously WEA Plan 3)** | **UHC Option 2 (Previously WEA Plan 2)** | **UHC Option 1 (Previously WEA Plan 5)** | **UHC HDHP Option 7 (Previously WEA QHDHP)** |
| **Transplants** | 100% after $100 copay/day for up to 3 days per admission. | May be subject to 12 month waiting period. See benefit booklet for contract details and limitations | May be subject to 12 month waiting period. See benefit booklet for contract details and limitations | May be subject to 12 month waiting period. See benefit booklet for contract details and limitations | May be subject to 12 month waiting period. See benefit booklet for contract details and limitations | May be subject to 12 month waiting period. See benefit booklet for contract details and limitations | May be subject to 12 month waiting period. See benefit booklet for contract details and limitations | May be subject to 12 month waiting period. See benefit booklet for contract details and limitations |
| **Voluntary Second Surgical Opinion** | 100% after a $15 copay/visit when received from GH provider. | **In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 50% | **In-Network:** $30, not subject to deductible<br>**Out-of-Network:** 50% | **In-Network:** $35, not subject to deductible<br>**Out-of-Network:** 50% | Not subject to deductible<br>**In-Network:** $30<br>**Out-of-Network:** $40 | Not subject to deductible<br>**In-Network:** $25<br>**Out-of-Network:** $30 | **In-Network:** $15, not subject to deductible<br>**Out-of-Network:** 70% | **In-Network:** 80%<br>**Out-of-Network:** 50% |
| **Weight-Loss Surgery (Bariatric surgery/Lap Band surgery)** | Not covered. | Not covered. | Not covered. | Not covered. | Not covered. | Not covered. | Not covered. | Not covered. |
| **Well-Baby/Child Care** | Well-care physicals, immunizations are covered at 100% according to Group Health's Well Child schedule. | See Preventive Care | See Preventive Care | See Preventive Care | See Preventive Care | See Preventive Care | See Preventive Care | See Preventive Care |
| **Wellness program (integrated with health plan)** | Not offered. | Simply Engaged | Simply Engaged | Simply Engaged | Simply Engaged | Simply Engaged | Simply Engaged | Simply Engaged |
| **Wigs** | Not covered. | Not covered. | Not covered. | Not covered. | Not covered. | Not covered. | Not covered. | Not covered. |