Hanford Joint Union High School District

Benefits Effective October 1, 2019

Summary of Benefits

MEDICAL BENEFITS

HealthNow 1-877-356-0666 www.MYHNAS.com
Blue Shield of California Providers www.blueshieldca.com

PPO Plan

	PPO In-Network	Non-PPO Out-of-Network**
Maximum Lifetime Benefit	Unlimited	Unlimited
Mental Health & Chemical Dependency	***See Mental Health & Chemical Dependency Section***	
DEDUCTIBLE (Calendar Year)	$200 Member/$500 Family	
Copays do not apply towards deductible		
OUT OF POCKET MAXIMUM (Calendar Year)		
Includes Copays and Deductible		
Member	$500	$1,000
Family	$1,500	$3,000

*** You will be responsible for any charge which exceeds the customary and reasonable amount.*

** Coinsurance After Deductible*

HOSPITAL SERVICES		
Participating Hospital	20%*	N/A
Non-Participating Hospital	N/A	50%**
Out Patient Surgery	20%*	50%**
Maternity Delivery Services	20%*	50%**
Ambulatory Surgical Center	20%*	50%, Max $350/procedure
Emergency Room	$100 Copay, waived if admitted, then 20%	
PHYSICIAN CARE		
Participating Physician		
Office Copay/Visit	$20 Copay	50%**
Specialist Office Copay/Visit	$20 Copay	50%**
Telehealth	No Charge	Not Covered
Hearing Examination, 1 per Year	$20 Copay	Not Covered
Hearing Test	20%*	Not Covered
Urgent Care	$25 Copay, then 20%	$25 Copay, then 50%**
Hospital	20%*	50%**
Out-Patient Surgical	20%*	50%**
Maternity Office Visits	20%*	Not Covered
PREVENTIVE CARE (Deductible does not apply)		
Routine Well Baby Care to age 2	No Charge	Not Covered
Includes: routine physical exam, laboratory test, x-rays, circumcision, and immunizations		
Limited to 10 visits from Birth to age 2		
Routine Well Child Care Age 2 and Over	No Charge	Not Covered
Includes: routine physical exam, laboratory test, x-rays and immunizations		
Limited to 1 visit per year		
Routine Well Adult Care	No Charge	Not Covered
Includes: pap smear, mammograms, prostate screenings, gynecological exam, routine physical exams, x-rays and laboratory tests.		
Frequency limits for mammogram:		
Age 35 through 39 single Baseline		
Age 40 through 49 every 2 years		
Age 50 and over, annually		
Adult Immunization (As recommended by U.S. Public Health Service)	No Charge	Not Covered
DIAGNOSTIC X-RAY/LAB	20%*	50%**

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SECOND SURGICAL OPINION	20%*	50%**
DURABLE MEDICAL EQUIPMENT (including hearing aids)	20%*	50%**
Maximum (including Hearing Aid)	$2,000 per calendar year	$2,000 per calendar year
Hearing Aid	1 Hearing Aid per canal every 3 years	1 Hearing Aid per canal every 3 years
ELECTIVE STERILIZATION	**PPO In-Network**	**Non-PPO Out-of-Network**
Co-Insurance Percentage	20%*	50%**
AMBULANCE		
Local Service	20%*	20%*
Air Ambulance	20%*	20%*
HOME HEALTH CARE		
100 visits per year	20%*	50%**
CHIROPRACTIC		
Office Copay	$20 Copay	50%** max $25/visit
Maximum Visits/Calendar Year	30 Visits	

MENTAL HEALTH & SUBSTANCE ABUSE		
Halcyon Behavioral 1-888-425-4800		
Inpatient Services	20%	50%
Inpatient Maximum Days/Calendar Year	Unlimited	Unlimited
Outpatient Services	$20 Copay	50%
Outpatient Maximum Visits/Calendar Year	Unlimited	N/A

PRESCRIPTION DRUG PLAN		
Envolve 1-800-498-9055	**Network Pharmacy**	**Mail Order**
	30 Day Supply	**90 Day Supply**
Generic - Formulary	$5 Copay	$10 Copay
Brand - Formulary	$20 Copay	$40 Copay
Non-Formulary Drugs	$20 Copay	$40 Copay
Oral Contraceptives	No Charge (not applicable to all brands)	No Charge (not applicable to all brands)

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Dental Plan Benefits

Delta Dental 1-866-499-3001

Class I - Major Services	1st Yr. - 70%, 2nd Yr. - 80%, 3rd Yr. - 90% or 4th Yr. & After - 100%*
Class II & III - Diagnostic, Preventive & Basic	1st Yr. - 70%, 2nd Yr. - 80%, 3rd Yr. - 90% or 4th Yr. & After - 100%*
Class IV - Accident Expense	1st Yr. - 70%, 2nd Yr. - 80%, 3rd Yr. - 90% or 4th Yr. & After - 100%*
Maximum per Calendar Year	$1,500
Orthodontics	No Benefit

In Network Benefits are paid according to Delta Dental Contracted Rates.
Out of Network Benefit Percentages are Paid According to Usual, Customary & Reasonable *(You will be responsible for any portion of the charge that exceeds Usual, Customary and Reasonable.)*

*Must use plan to progress to next level

VISION PLAN

Vision Service Plan (800) 877-7195

	VSP In Network	Non-VSP Out of Network
Eye Examination	$25 Copay	$45 Allowance
Lens Allowances		
Single	Covered In Full	$30 Allowance
Bi-Focal	Covered in Full	$50 Allowance
Tri-Focal	Covered in Full	$65 Allowance
Lenticular	Covered in Full	$100 Allowance
Contacts	Up to $130	$105 Allowance
Tints #1 and #2	Covered In Full	Scheduled Allowance
Cosmetic Contacts	In Lieu of Glasses	In Lieu of Glasses
Frames	Up to $180	$70 Allowance
Frequency		
Examination	Every 12 Months	
Lenses	Every 12 Months	
Contacts	Every 12 Months	
Frames	Every 24 Months	

LIFE and AD & D

$20,000- All Eligible Employees

NOTE: This summary information is intended for comparison purposes only and is subject to change. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

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, visit www.myhnas.com or call 1-877-356-0666. 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 www.myhnas.com or call 1-877-356-0666 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in- and out-of-network providers combined $200/person and $500/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care, some benefits subject to a copay, and prescription drug expenses.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
What is the out-of-pocket limit for this plan?	For in-network providers $500/person and $1,500/family. For out-of-network providers $1,000/person and $3,000/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription drug copays, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.blueshield.com/networkPPO or call 1-800-541-6652 for a list of network providers in CA; or 1-800-810-2583 outside of CA.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-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/visit. Deductible does not apply.	50% coinsurance*	An office visit includes all services rendered in the office during the visit.
	Specialist visit	$20/visit. Deductible does not apply.	50% coinsurance*	
	Telehealth	No charge. Deductible does not apply.	Not covered	None
	Chiropractic visit	$20/visit. Deductible does not apply.	50% coinsurance* to a maximum of $25/visit.	Limited to 30 visits/year.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	Includes preventive services as mandated by ACA. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Includes 3D mammograms.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance*	50% coinsurance*	Includes 3D mammograms.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	50% coinsurance*	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance*	50% coinsurance* to a maximum of $350/procedure	None
	Physician/surgeon fees	20% coinsurance*	50% coinsurance*	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $100/visit. Deductible does not apply.	Paid as in-network	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance*	Paid as in-network	None
	Urgent care	20% coinsurance after $25/visit. Deductible does not apply.	50% coinsurance* after $25/visit.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	50% coinsurance*	Precertification required.**
	Physician/surgeon fees	20% coinsurance*	50% coinsurance*	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services **(Halcyon Behavioral - 1-888-425-4800)**	Outpatient services	$20/visit. Deductible does not apply.	50% coinsurance	Certain behavioral health services are not covered.
	Inpatient services	20% coinsurance	50% coinsurance	Precertification required.** Certain behavioral health services are not covered.
If you are pregnant	Office visits	20% coinsurance*	Not covered	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
	Childbirth/delivery professional services	20% coinsurance*	50% coinsurance*	None
	Childbirth/delivery facility services	20% coinsurance*	50% coinsurance*	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	50% coinsurance*	Limited to 100 visits/year.
	Rehabilitation services – physical, speech, occupational & other rehabilitative therapies	20% coinsurance*	50% coinsurance*	Speech therapy is limited to 20 visits/year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance*	50% coinsurance*	Limited to 100 days/year.
	Durable medical equipment	20% coinsurance*	50% coinsurance*	Limited to $2,000/year.
	Hearing aids	20% coinsurance*	50% coinsurance*	Limited to a max of $2,000/year; further limited to 1 unit per canal per every 3 years.
	Hospice services	20% coinsurance*	50% coinsurance*	Bereavement counseling is limited to 15 visits.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Refer to your Vision plan.
	Children's glasses	Not covered	Not covered	Refer to your Vision plan.
	Children's dental check-up	Not covered	Not covered	Refer to your Dental plan.

* Deductible applies.

** Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services may result in a reduction of benefits.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.usscript.com	Generic drugs	$5/prescription. Deductible does not apply.	$10/prescription. Deductible does not apply.	Certain medications considered preventive care under ACA are payable at no cost-share to the member. The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a preferred or non-preferred brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the preferred or non-preferred brand name drug and the generic equivalent, plus the generic co-pay unless the physician specifies "Dispense as Written". A 90-day supply may be obtained at Costco pharmarcies for a 2x-copay charge.
	Preferred brand drugs	$20/prescription. Deductible does not apply.	$40/prescription. Deductible does not apply.	
	Non-preferred brand drugs	$20/prescription. Deductible does not apply.	$40/prescription. Deductible does not apply.	

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
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care in excess of the Plan's maximum limits
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- 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, limited to morbid obesity
- Chiropractic care
- Hearing aids
- Inpatient private duty nursing

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: HealthNow Administrative Services, 1-877-356-0666, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

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 the 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-356-0666.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-356-0666.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	$200
Specialist copayment	$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$20
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$580**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$140
Copayments	$790
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$990**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$140
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$590**

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