



Fresno Unified School District

Fresno Unified School District
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www.JHMBHealthConnect.com

Upcoming Changes to Your Medical & Prescription Drug Benefits and Your Latest Summary of Benefits and Coverage

TO: Fresno Unified School District Employee Health Care Plan Participants in Plan Options A and B

DATE: November 1, 2017

The Joint Health Management Board (JHMB) has updated the Summary of Benefits and Coverage (SBC) for Plan Options A and B effective January 1, 2018. Please take note of the following updates to the SBCs for Plan Options A and B enclosed in this packet.

ADDITION TO MEDICAL PLAN BENEFIT

Addition of Planned Surgery Benefit through BridgeHealth

Effective January 1, 2018, the JHMB is partnering with BridgeHealth to offer a new planned surgery benefit that covers 100% of the costs for non-emergency surgeries - ***no deductible, no coinsurance!*** BridgeHealth partners with top-rated providers to help improve surgical outcomes (such as fewer complications and lower infection rates) and reduce costs for many surgical procedures.

CHANGE TO PRESCRIPTION PLAN FORMULARY

NOTE: This change does NOT apply to the EnvisionRx Plus Medicare Part D Prescription Plan

Effective January 1, 2018, EnvisionRx and the JHMB will implement Envision Rx's Select Formulary for Plan Options A and B. Under the Select Formulary program, the JHMB's existing 4 copay tiers remain, however the drugs available within those tiers may change based on the latest Envision Rx standards. EnvisionRx will send more detailed communications to ***impacted plan participants only*** regarding which drugs are affected by the Select Formulary drug list.

CHANGE TO MENTAL HEALTH TREATMENT BENEFIT

Effective January 1, 2018, the JHMB has modified the behavioral health benefit related to mental health outpatient and inpatient treatment. The calendar year visit maximums have been increased.

A SPECIAL NOTE ABOUT YOUR SUMMARY OF BENEFITS & COVERAGE

The SBC provides you with a quick snapshot of what your plan covers and what it costs. This includes important answers regarding your deductibles, out-of-pocket limits, common medical


events, and the types of services covered or excluded from the plan. The SBC also includes your rights to continue coverage, grievance and appeals rights, and coverage examples.

Please keep in mind the SBC is a summary illustration of your benefits plan. The Benefits Plan Booklet is the official governing document for your benefits plan. Review the Benefits Plan Booklet for specific details about your benefits plan. The Plan Booklet is accurate as August 2012, and any amendments to the Plan Booklet are available online at www.JHMBHealthConnect.com/your-benefits. As amendments are made available, you should make them a part of the Plan Booklet.

FOR MORE INFORMATION


As a reminder, you may visit www.JHMBHealthConnect.com/your-benefits to review the Benefits Plan Booklet and related amendments. If you are unable to access the website, you can contact the District's Benefits Office to request a copy.

FUSD Benefits Office
2309 Tulare Street
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 **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.jhmbhealthconnect.com. 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.jhmbhealthconnect.com or call 1-559-457-3520 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network Providers</u> : \$1,000 Individual/\$2,000 Family. <u>Out-of-Network Providers</u> : \$3,000 Individual/\$6,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> 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 <u>deductible</u>?	Yes. <u>Preventive care</u> , <u>hospice</u> , <u>prescription drugs</u> , chiropractic care, acupuncture, ambulance, inpatient mental health or substance abuse care, and services covered under the planned surgery benefit.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network Providers</u> : Medical and Mental Health / Substance Abuse Combined - \$5,700 Individual/\$11,400 Family; Prescription \$900 Individual/\$1,800 Family. <u>Out-of-Network Providers</u> : Medical only - \$12,000 Individual/\$24,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, <u>balance-billing</u> charges, penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. For a list of <u>network providers</u> , see/call: Medical - www.anthem.com/ca or 1-800-807-0820; Mental Health / Substance Abuse - www.fusdmentalhealth.com or 1-800-498-9055.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an

		<u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		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	\$25 <u>copay</u> /office visit, and 30% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /office visit, and 30% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition; for those enrolled in the <u>standard prescription plan</u>. (If you are enrolled in the Medicare approved plan, <u>EnvisionRx Plus</u> , see following page.) More information about <u>prescription drug coverage</u> is available at www.envisionrx.com	Tier 1 - Generic drugs used for treating high cholesterol, high blood pressure, diabetes, and depression	No charge	Not covered	All maintenance medications must be filled with a 90-day supply, and must use the Rx90 Network (EnvisionMail, Rite Aid, Walgreens and Costco retail pharmacy) (effective July 1, 2017) 90-day supply: Requires two 30-day copays. 30-day and 90-day supplies at retail; 90-day supplies at mail order. The prescription plan uses EnvisionRx's Select Formulary. The formulary list is available at www.EnvisionRx.com .
	Tier 2 - Generic drugs	\$10 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	
	Tier 3 - Preferred brand drugs	\$35 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	
	Tier 4 - Non-preferred brand drugs	\$50 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Patient pays cost difference for brand with generic alternative
For those enrolled in the Medicare approved plan, EnvisionRx Plus. More information about prescription drug coverage is available at www.envisionrxplus.com	Generic drugs	\$10 <u>copay</u> /prescription Retail and Mail Order	Not Covered	Retail: Covers up to 30-day supply; Up to 90-day supply for maintenance and non-maintenance drugs
	Brand drugs with generic equivalent	\$35 <u>copay</u> /prescription Retail and Mail Order	Not Covered	Mail Order: Covers up to 90-day supply for non-maintenance drugs; Up to 180-days for maintenance drugs
	Brand drugs with no generic equivalent	\$35 <u>copay</u> /prescription Retail and Mail Order	Not Covered	Patient pays cost difference for brand with generic equivalent
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> plus 30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250. No charge for covered services under the planned surgery benefit.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	No charge for covered services under the planned surgery benefit.
If you need immediate medical attention	Emergency room care	\$100 <u>copay</u> plus 30% <u>coinsurance</u>	\$100 <u>copay</u> plus 30% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	\$100 <u>copay</u> plus 30% <u>coinsurance</u> for Ground; No Charge for Air <u>Deductible</u> does not apply	\$100 <u>copay</u> plus 30% <u>coinsurance</u> for Ground; No Charge for Air <u>Deductible</u> does not apply	None
	<u>Urgent care</u>	\$35 <u>copay</u> plus 30% <u>coinsurance</u>	\$35 <u>copay</u> plus 50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250. No charge for covered services under the planned surgery benefit.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	No charge for covered services under the planned surgery benefit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	Mental/Behavioral Health Outpatient services	\$10 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not Covered	<u>Preauthorization</u> is required. Maximum 60 visits per calendar year.
	Mental/Behavioral Health Inpatient services	No Charge	Not Covered	<u>Preauthorization</u> is required. Maximum 45 days per calendar year.
	Substance Abuse Outpatient services	No Charge	Not Covered	<u>Preauthorization</u> is required.
	Substance Abuse Inpatient services	No Charge	Not Covered	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	\$25 <u>copay</u> /office visit, and 30% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Cost sharing does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC. Dependent Children are only covered for <u>preventive services</u> as defined under the Affordable Care Act.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Maximum 120 days per calendar year. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250.
	<u>Hospice services</u>	No Charge	No Charge	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered under Medical Plan	Not Covered under Medical Plan	
	Children's glasses			
	Children's dental check-up			

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.)

• Cosmetic Surgery	• Dental Care (Adult)	• Genetic Testing
• Hearing Aids	• Infertility Treatment	• Long-Term Care
• Routine Eye Care (Adult)	• 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.)

• Acupuncture (through PhysMetrics)	• Bariatric Surgery	• Chiropractic Care (through PhysMetrics)
• Non-emergency care when traveling outside United States	• 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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: Delta Health Systems at 1-800-807-0820.

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 1-559-457-3596. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-559-457-3596. Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-559-457-3596.

—————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 <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	\$12,731
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$83
Coinsurance	\$3,388
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,531

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	\$7,389
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$122
Copayments	\$1,030
Coinsurance	\$455
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,662

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$777
Copayments	\$250
Coinsurance	\$196
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,223