South Harrison School District 2019-2020
Benefit Options Overview

Medical Coverage Selections - Schools Health Insurance Fund

MEDICAL BENEFITS	Aetna Pat V $10 Gold		Aetna Pat V $10 Silver		Aetna Open Access Bronze $20		HDHP $1350/$2700		Horizon Omnia	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	Tier 1	Tier 2
Deductible	None	$100 Individual	None	$100 Individual	$500 Individual	$1,250 Individual	$1,350 Induvial	$1,350 Individual	None	$1,500 Individual
	None	$200 Family	None	$200 Family	$1,000 Family	$2,500 Family	$2,700 Family	$2,700 Family	None	$3,000 Family
Out of Pocket Limit	$5,300 Induvial	$2,000 Individual	$5,300 Induvial	$2,000 Individual	$1,000 Individual	$2,500 Individual	$6,250 Induvial	$6,250 Individual	$2,500 Induvial	$4,500 Individual
	$10,600 Family	$4,000 Family	$10,600 Family	$4,000 Family	$2,000 Family	$5,000 Family	$12,500 Family	$12,500 Family	$5,000 Family	$9,000 Family
Primary Care	$10 copay	70% after deductible	$10 copay	70% after deductible	$20 copay	70% after deductible	80% after deductible	50% after deductible	$5 copay	$20 copay
Specialist	$15 copay	70% after deductible	$15 copay	70% after deductible	$30 copay	70% after deductible	80% after deductible	50% after deductible	$15 copay	$30 copay
Preventive	No Charge	70% after deductible (OBGYN not covered)	No Charge	70% after deductible (OBGYN not covered)	No Charge	Not Covered	No Charge	50% after deductible	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge for labs; $15 copay for x-ray	70% after deductible	No Charge for labs; $15 copay for x-ray	70% after deductible	$30 copay	70% after deductible	80% after deductible	50% after deductible	No charge for office or lab; $15 for outpatient hospital	No charge office/lab; 80% after deductible for outpatient hospital
Outpatient Surgery	No Charge	70% after deductible	No Charge	70% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible	$150 copay	80% covered after deductible
Emergency Room	$50 copay	$50 copay	$50 copay	$50 copay	$100 copay	$100 copay	80% after deductible	80% after deductible	$100 copay	$100 copay
Emergency Transportation	No Charge	No Charge	No Charge	No Charge	90% after deductible	70% after deductible	80% after deductible	80% after deductible	No Charge	Deductible Applies
Urgent Care	$15 copay	70% after deductible	$15 copay	70% after deductible	$30 copay	$30 copay	80% after deductible	50% after deductible	$15 copay	$30 copay
Hospital Stay	No Charge	70% after deductible	No Charge	70% after deductible	$100 copay per day, $500 max per admission	70% after deductible	80% after deductible	50% after deductible	$150 copay	80% covered after deductible
Monthly Premium Rates 7/1/2019 - 6/30/2020	Aetna Pat V $10 Gold		Aetna Pat V $10 Silver		Aetna Open Access Bronze $20		HDHP $1350/$2700		Horizon Omnia	
	Single $869.00		Single $869.00		Single $759.00		Single $908.00		Single $744.00	
	Parent/Child(ren) $1,270.00		Parent/Child(ren) $1,270.00		Parent/Child(ren) $1,107.00		Parent/Child(ren) $1,245.00		Parent/Child(ren) $1,070.00	
	Employee/Spouse $1,902.00		Employee/Spouse $1,902.00		Employee/Spouse $1,604.00		Employee/Spouse $1,908.00		Employee/Spouse $1,613.00	
	Family $2,226.00		Family $2,226.00		Family $1,939.00		Family $2,257.00		Family $1,892.00	
PRESCRIPTION PLANS	**Retail Copays -(34 days or 100 units)**		**Retail Copays -(30 days supply)**		**Retail Copays -(30 days)**		**Retail Copays -(30 days supply)**		**Retail Copays -(30 days)**	
	Generic - $5 copay		Generic -$10 copay		Generic -$15 copay		80% after deductible		Generic -$15 copay	
	Brand Drugs - $10 copay		Preferred Brand $20 / Non Preferred Brand $30		Preferred Brand $30 ; Non Preferred Brand $45				Preferred Brand $30 ; Non Preferred Brand $45	
	Mail Order (90 days) - $0 copay		**Mail Order (90 days) -**		**Mail Order (90 days) -**		**Mail Order (90 days)**		**Mail Order (90 days) -**	
*Prior authorization may be required for certain services.			$5 Generic/$10 Preferred/$10 Non-Preferred		$15 Generic/$30 Preferred/$45 Non-Preferred		80% after deductible		$15 Generic/$30 Preferred/$45 Non-Preferred	
	Single $396.00		Single $288.00		Single $253.00				Single $253.00	
	Parent/Child(ren) $477.00		Parent/Child(ren) $346.00		Parent/Child(ren) $305.00		Rx Cost Included in Medical Premium		Parent/Child(ren) $305.00	
	Employee/Spouse $768.00		Employee/Spouse $561.00		Employee/Spouse $489.00				Employee/Spouse $489.00	
	Family $928.00		Family $675.00		Family $592.00				Family $592.00	

DENTAL BENEFIT - Delta Dental PPO Plus Premier Advantage Plan

Preventive & Diagnostic - covered 100%

Remaining Basic - covered 80%

Crowns and Prosthodontics - covered 50%

Calendar Year Maximum (per patient) - $1,000

Calendar Year Deductible (waived for preventive/diagnostic) $100/$300

Dental Monthly Rates 7/1/19 - 06/30/2020
Single $43.00
Parent/Child(ren) $73.00
Employee/Spouse $73.00
Family $148.00

Need Help With Your Benefits or Have a Benefits Question?

Contact the BeneService Member Advocacy Team at 800.563.9929 or cssteam@connerstrong.com

This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical, prescription, dental, and vision programs. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.