Benefits

Employee Guide 2019

BCSC

DEEPER LEARNING WORKS

SIHO INSURANCE SERVICES

INTRODUCTION

The Bartholomew Consolidated School Corporation administration, the health trust and teachers have worked with SIHO, your employee benefits administration company, to develop a benefits plan for you and your eligible dependents.

One of the advantages of SIHO is their focus on and attention to customer service. SIHO's helpful staff is ready to assist you with any questions or concerns you may have. Employees are encouraged to contact SIHO by phone at (812) 378-7070 or (800) 443-2980 toll free.

The local customer service staff includes:

- **Member Services**—Representatives who will help you understand your health care benefits and walk you through the claims process with phone and walk-in accessibility.
- **Medical Management**—Nurses are available on-site in Columbus to answer any medical questions you might have or to work with your physician to ensure you receive the highest quality health care.
- **Account Management**—These individuals work with your employer and claims representatives to help them improve the benefit program and to resolve any concerns during the contract period.

Though BCSC cannot avoid the impact of rising health care costs, we believe this health care plan will provide many advantages while living within the corporation's budget demands.

Advantages of the BCSC Plan:

- Two health plans - offering a choice in health care coverage
- Preventive health care coverage

Working Spouse Rule:

The purpose of the Working Spouse Rule is to share the costs of the medical, dental and vision expenses with other plans or insurance carriers when the spouse of an Employee is eligible for medical, dental and vision coverage where the spouse is employed. It is the Employer's responsibility to determine who is eligible for this coverage on a non-discriminatory basis.

1. If a spouse of an eligible Employee is employed with a company which offers group medical, dental and vision insurance coverage and that spouse is eligible for that plan, that spouse will not be eligible for this Plan.
2. If the spouse is employed with a company that does not offer group medical, dental and vision coverage and is eligible to be enrolled, the spouse may be enrolled in this Plan as primary at the family rate which is currently in effect. (A statement from the spouse's employer that verifies they have no coverage available with that employer will be required.)*

If an employee and spouse are found to be in violation of the provision, claims for the spouse will be the responsibility of the employee from the time the violation began.

**Note: Medicare does not count as an employer-sponsored plan for the purposes of this rule.*

TERMS IN THIS BENEFITS GUIDE

Copays – The flat fee charged by the plan for certain services such as emergency room visits or office visits.

Annual Deductible – The amount you pay first before the plan begins paying expenses for covered services.

Coinsurance Stop-Loss – The amount you pay each year in coinsurance before covered expenses are paid at 100% by the Plan. This amount does not include the annual deductible.

Coinsurance – The percentage you pay when you receive care once you have met the annual deductible.

Balance Billing – Provider practice of billing the patient for the difference (or balance) of charges above the amount reimbursed by the health plan. Your plan prohibits participating providers from balance billing except for allowed copayments, coinsurance and deductibles.

Reasonable & Customary – A payment rate based on the fees for medical services charged by health care providers in a specified area (usually a zip code or group of related zip codes).

Primary and Secondary Benefit Coverage (Benefit Less Benefit) – The integration of benefits payable under more than one health insurance plan that the insured may have. For BCSC members with health insurance coverage from more than one plan, the claim is processed with the primary carrier's benefit levels. In the event the primary benefit is less than secondary coverage, additional payment will be made to the claim.

Annual Max—Maximum payable under the employer's plan per person per calendar year.

Customer Service:

SIHO has customer service representatives available to answer your questions relating to eligibility, benefits and claim status. You can also log on to their website and click on *Contact Us* to reach a customer service representative.

Phone: 812-378-7070
Website: www.siho.org
Address: 417 Washington Street
P.O. Box 1787
Columbus, IN 47202-1787

To find out if your provider is part of the Network or to find a provider in any Network, call SIHO Customer Service or log on to the website to do a search: **www.siho.org**

SUMMARY OF HEALTH CARE BENEFITS

Your Plan Features	Option 1 - HIGH DEDUCTIBLE PLAN			Option 2 - PPO Plan		
	Inspire Health Partners	Encore/SIHO Landmark	Out-of-Network	Inspire Health Partners	Encore/SIHO Landmark	Out-of-Network
Annual Maximum	Unlimited			Unlimited		
Calendar Year Deductible Individual Family	$1,500 $3,000	$2,000 $4,000	$2,500 $5,000	$750 $1,500	$1,000 $2,000	$2,000 $4,000
	The High Deductible Health Plan (Option 1) has a non-embedded deductible. For family policies, the individual deductible is non-applicable. However, the maximum out-of-pocket will never exceed the maximum single out of pocket per tier.			The Preferred Provider Plan (Option 2) has an *embedded* deductible. This means that one member must meet the individual deductible and the remaining family member(s) can accumulate the remaining amount to meet the family deductible in each tier.		
Calendar Year Coinsurance Stop Loss Maximum Individual Family	$2,500 $5,000	$3,500 $6,000	$4,000 $7,000	$2,000 $4,000	$3,000 $5,000	$4,000 $6,000
Maximum Out-of-Pocket Individual Family	$4,000 $8,000	$5,500 $10,000	$6,500 $12,000	$2,750 $5,500	$4,000 $7,000	$5,000 $10,000
	All tiers deductibles & coinsurance cross apply. Copays accumulate toward the maximum out-of-pocket.			All tiers deductibles and coinsurance cross apply. Copays accumulate toward the maximum out-of-pocket		
Hospital Room, Services, Supplies	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Inpatient Surgery	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Emergency Room Facility Charges	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Urgent Care	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Outpatient Surgery	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Office Visits	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Preventive Health Benefit	100% covered-subject to Preventive Health Benefits Guidelines			100% covered-subject to Preventive Health Benefits Guidelines		
Diagnostic X-Ray and Lab	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Ambulance	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Inpatient Mental Health and Substance Abuse	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Outpatient Mental Health and Substance Abuse	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Physical, Speech & Occupational Therapy	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible

SUMMARY OF HEALTH CARE BENEFITS

You Plan Features	Option 1 - HIGH DEDUCTIBLE PLAN			Option 2 - PPO Plan		
	Inspire Health Partners	Encore/SIHO Landmark	Out-of-Network	Inspire Health Partners	Encore/SIHO Landmark	Out-of-Network
Chiropractic Services	Annual Maximum: 6 visits			Annual Maximum: 20 visits		
	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Durable Medical Equipment	Precertification required for purchases over $750 and all rentals			Precertification required for purchases over $750 and all rentals		
	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Hospice Care	Precertification required; combined Calendar year maximum: 3 months outpatient; 6 months inpatient			Precertification required; combined Calendar year maximum: 3 months outpatient; 6 months inpatient		
	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible
Home Health Care Outpatient	Precertification required; Annual max 60 visits			Precertification required; Annual max 60 visits		
	85% after deductible	85% after deductible	85% after deductible	85% after deductible	75% after Deductible	60% after deductible
Other Covered Benefits	85% after deductible	75% after Deductible	60% after deductible	85% after deductible	75% after Deductible	60% after deductible

YOUR COST FOR COVERAGE

Your cost for **medical coverage** is based upon the plan you choose level of coverage. The table below shows your contribution for each plan:

	2019 Per Pay Employee Share (20 pay)	2019 Per Pay Employee Share (26 pay)
Option #1 (HSA)		
Single	$ 46.03	$ 35.40
Family	$ 126.28	$ 97.14
Single - Wellness	$ 33.53	$ 25.79
Family - Wellness	$ 113.78	$ 87.53
Family & Spouse Wellness	$ 101.28	$ 77.91
Option #2 (PP0)		
Single	$ 115.87	$ 89.13
Family	$ 356.87	$ 274.52
Single - Wellness	$ 103.37	$ 79.52
Family - Wellness	$ 344.37	$ 264.90
Family & Spouse Wellness	$ 331.87	$ 255.29

BCSC Wellness Program

Employees participating in the wellness program will receive a $250 credit or a $500 (if the spouse participates) credit towards their contributions to the health plan if all of the following criteria is met by both employee and spouse before July 31, 2019:

1. Completion of the Health Risk Assessment;
2. Completion of the Biometric Screening;
3. Meet with a Columbus Regional Health or BCSC Health Center Health Coach to review you're assessment and set goals.
4. Complete an annual Preventive Health exam.
5. Complete an annual vision and dental exam.

SUMMARY OF PRESCRIPTION DRUG COVERAGE

Your Plan Features*	Option 1 - High Deductible Health Plan*		Option 2 - Preferred Provider Plan	
	Retail Service (30 day supply)	Mail Order Service (90 day supply)	Retail Service (30 day supply)	Mail Order Service (90 day supply)
Generic	$12 after deductible	$24 after deductible	$12	$24
Brand	$40 after deductible	$80 after deductible	$40	$80
Non Formulary Brand	$75 after deductible	$150 after deductible	$75	$150

* Prescription Drugs listed on the High Deductible Health Plan Health Savings Account Preventive Therapy Drug List will be covered at the appropriate copay and not subject to the annual deductible.

- **Your plan has added Maintenance Choice with an opt out provision. After two 30 day fills of a maintenance drug (prescription drugs taken for 90 days or longer) at a retail pharmacy, you will be required to fill a 90 day prescription at either a CVS retail pharmacy or CVS/Caremark mail order facility. This will save you time and money as you will get a 90 day fill for the price of two 30 day fills. If you prefer not to change to a 90 day supply, you must call CVS/Caremark at (800) 364-6331 and opt out of the program.**
- **To obtain your prescriptions though Elect RX, please see detailed instructions on the BCSC website.**

1. **Your plan utilizes the Caremark Value Formulary for prescription drugs. Prescription drugs that are not listed on the formulary are not covered. If your doctor recommends a prescription drug not on this formulary, prior authorization is required.**
2. **If a generic drug is available and either the provider or member preference to elect the brand name drug, the pricing difference will be added to the above copays.**

SUMMARY OF DENTAL COVERAGE

Another advantage of the BCSC plan is dental coverage through Delta Dental. This plan includes a comprehensive dental plan that emphasizes preventive care, covering 100% of the preventive dental care, 80% of basic and major services and 60% of orthodontic services. Please refer to the Delta Dental brochures for further details on benefits, limitations and procedures for obtaining benefits under the Plan. This coverage is not associated with the BCSC health insurance plan through SIHO. For benefit questions or to find a participating provider, call Delta Dental at (800) 524-0149 or go to their website at www.deltadentalin.com.

Here is an overview of some of the services and coverage you receive:

MAXIMUM BENEFITS

Annual Deductible Individual Family	$50 $100
Maximum Annual Benefit per Person	$1,500
Maximum Lifetime benefit for Orthodontia	$1,000

COINSURANCE

Benefit	Participating Provider	Non-Participating Provider
Preventive / Diagnostic Services	100%, no deductible	90%, no deductible
Basic Services	80% after deductible	60% after deductible
Major Services	80% after deductible	60% after deductible
Orthodontia for Children under age of 19	60% after deductible	50% after deductible

The following table shows your contribution for **dental coverage**:

Employee Premiums	(26 pay periods)	Support/ Adm. Assistants (20+ pay periods)	Support (9 month employees)
Individual Coverage	$8.12	$10.56	$10.56
Family Coverage	$23.03	$29.94	$29.94

SUMMARY OF VISION COVERAGE

Your Vision Benefits Summary

Get access to the best in eye care and eyewear with BARTHOLOMEW CONSOLIDATED SCHOOL CORPORATION and VSP® Vision Care.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** The decision is yours to make—with the largest national network of private-practice doctors, it's easy to find the in-network doctor who's right for you. Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best Eye Care

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

Plan Information

VSP Coverage Effective Date: 01/01/2019
VSP Provider Network: VSP Signature

BARTHOLOMEW CONSOLIDATED SCHOOL CORPORATION and VSP provide you with an affordable eyecare plan.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$25
Frame	• $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 24 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Tints/Photochromic adaptive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every 24 months	$0 $0 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 24 months	Up to $60
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	
Your Coverage with Out-of-Network Providers		
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.		

VSP guarantees coverage from VSP network providers only. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

We know the health care decisions you make are very important. You deserve all the information you need to make the right choices for you and your family. After reviewing this benefit guide, please feel free to contact Columbus SIHO Member Services at **(812) 378-7070** or **Toll Free (800) 443-2980** with any questions**.**

This brochure is for informational purposes only and it is not intended to serve as a legal interpretation of benefits. The entire provisions of benefits and exclusions are contained in the Summary Plan Description (SPD), Certificate and Schedule of Benefits. In the event of a conflict between the SPD and this Guide, the terms of the SPD will prevail.

Note:

This is only a brief description available under the plans. For a more detailed description of coverage, benefits, limitations and exclusions, please refer to the applicable certificate of coverage or the summary plan description.

SIHO INSURANCE SERVICES

www.siho.org

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