Greater Clark County Schools Corporation: PPO Plan

Coverage for: Individual +Family | Plan Type: PPO

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 Patricia Helton phelton@gccschools.com or by calling 812-288-4802.ext 50146 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.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 812-288-4802.ext 50146 to request a copy

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $1,000 Individual / $2,000 Family Non-Network Providers: $3,000 Individual / 6,000 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 Certain Office Visits, Emergency Room Care, Urgent Care, Prescription Drugs and Certain therapies. And is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Providers $2,500 Individual / $5,000 Family; Non-Network Providers: $7,500 Individual / $15,000 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?	Premiums, Balance-billing charges, Health care this plan doesn't cover, Penalties, Non-network Transplant Non-Network Prescription Drugs, Non-network Specialty Drugs.	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. www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of network providers	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, 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
		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 copay/visit deductible does not apply	40% after deductible	None
	Specialist visit	$40 copay/visit deductible does not apply	40% after deductible	None
	Preventive care/screening/ immunization	No charge	40% after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% after deductible	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	No charge	40% after deductible	- Cost share may vary based on where service is performed. - Preauthorization may be required - if not obtained, penalty will be 50%
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.humana.com	Level 1 - Lowest cost generic and brand-name drugs	$10 copay (Retail) $25 copay (Mail Order)	PAR copayment + 30% + the difference between the default rate and the Non-PAR pharmacy charge/Rx	30 day supply (retail) 90 day supply (mail order) - Pharmacy Out-of-Pocket limit for PAR providers: $3,500 single/$7,000 family; For Non-PAR providers: Not applicable. - Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs.
	Level 2 - Higher cost generic and brand-name drugs	$30 copay (Retail) $75 copay (Mail Order)		
	Level 3 - Generic and brand-name drugs with higher cost than Level 2:	$50 copay (Retail) $125 copay (Mail Order)		
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)		
	Specialty drugs (pharmacy) Office Administered Rx	No charge	Not covered	Preauthorization may be required - if not obtained, penalty will be 100% for certain

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)	
				prescription drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	40% after deductible	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	No charge	40% after deductible	None
If you need immediate medical attention	Emergency room services True Emergency Non-Emergency	$100 copay/visit deductible does not apply $100 copay/visit deductible does not apply	$100 copay/visit deductible does not apply 40% after deductible	Copay waived if admitted
	Emergency medical transportation	$50 copay/visit deductible does not apply	20% after deductible	None
	Urgent care	$50 copay/visit deductible does not apply	40% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	40% after deductible	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	No charge	40% after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit deductible does not apply	40% after deductible	None
	Inpatient services	20% after deductible	40% after deductible	None
If you are pregnant	Office visits	$25 PCP/$40 specialist copay/visit; deductible does not apply	40% after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	40% after deductible	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services	20% after deductible	40% after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health	Home health care	20% after deductible	40% after deductible	- 100 visits per year Preauthorization may be required - if not obtained, penalty will be 50%

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)	
needs	Rehabilitation services	$40 copay/visit deductible does not apply	40% after deductible	- 20 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Habilitation services	$40 copay/visit deductible does not apply	40% after deductible	- 20 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Skilled nursing care	20% after deductible	40% after deductible	- 60 days per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	20% after deductible	40% after deductible	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. - Preauthorization may be required - if not obtained, penalty will be 50%
	Hospice services	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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, unless it is prescribed by a physician for rehabilitation purposes
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult), unless for an eye exam
- 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.)

- Chiropractic Care – spinal manipulations are covered
- Infertility Treatment

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 Labor's, Employee Benefits Security Administration at 1-866-444-EBSA (3272). 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:

- Your plan at 812-288-4802.ext 50146
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes/No
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 1-866-4ASSIST (427-7478).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-4ASSIST (427-7478).
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-4ASSIST (427-7478).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-4ASSIST (427-7478)

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	$1000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other	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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$80
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,040

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

The plan's overall deductible	$1000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other	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	$0
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,100
The total Joe would pay is	$2,800

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

The plan's overall deductible	$1000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other	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	$400
Copayments	$1,400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235, or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-877-320-1235 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-320-1235 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-1235 (TTY: 711)**.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-320-1235（TTY: 711）**。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-320-1235 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-877-320-1235 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-320-1235 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-320-1235 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-320-1235 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-320-1235 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-320-1235 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-320-1235 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-320-1235 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-320-1235 (TTY: 711)**.

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 **1-877-320-1235（TTY：711）**まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-877-320-1235 (TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-877-320-1235 (TTY: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-320-1235 (رقم هاتف الصم والبكم: 711)**.