Pinellas County Schools: CDHP Plan

Coverage for: Individual +Family | **Plan Type:** CDHP

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, April Paul paula@pcsb.org or by calling 727-588-6136. 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 727-588-6136to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $1,500 Individual / $3,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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 is covered.	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?	Yes, for prescription drug coverage. Network Providers: $250 Individual / $500 Family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Out-of-Pocket: Network Providers **$4,500** Individual / **$9,000** Family. Plan Maximum Out-of-Pocket limit for Network Providers: **$6,250** Individual / **$12,500** Family. Out-of-Network Providers: **N/A**	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	No.	You can see the specialist you choose without a referral.

see a specialist?		

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	20% after deductible	Not covered	None
	Specialist visit	20% after deductible	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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)	20% after deductible	Not covered	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	20% after deductible	Not covered	- 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:	$20 copay/Rx (Retail) $40 copay/Rx(Mail Order)	PAR copay + 30% + the difference between the default rate and the Non-PAR pharmacy charge/script	- 30 day supply (retail) - 90 day supply (mail order) Pharmacy Deductible: $250 Individual / $500 Family (Applies to Levels 3 & 4). - Preauthorization may be required for step therapy and certain prescription drugs. If not obtained, penalty will be 100%. Pharmacy Out-of-Pocket limit Network Providers: $6,250 Individual / $12,500 Family
	Level 2 - Higher cost generic and brand-name drugs:	$50 copay/Rx (Retail) $100 copay/Rx(Mail Order)		
	Level 3 - Generic and brand-name drugs with higher cost than Level2	$90 copay/Rx(Retail) $180 copay/Rx(Mail Order)		
	Level 4 - Highest cost drugs	$120 copay/Rx (Retail) $240 copay/Rx(Mail Order)		
	Specialty Drugs Drugs purchased at a pharmacy Covered under the medical plan Office administered and provided by Specialty Rx	Same as Level 1, 2, 3 or 4 Medical Benefits Apply No charge	Not covered	Specialty office medications and injectable drugs do not include self-administered injectable drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	Not covered	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	20% after deductible	Not covered	None
If you need immediate medical attention	Emergency room care	20% after deductible	20% after PAR deductible	None
	Emergency medical transportation	20% after deductible	20% after PAR deductible	None
	Urgent care	20% after deductible	20% after PAR deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	Not covered	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	20% after deductible	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% after deductible	Not covered	None
	Inpatient services	20% after deductible	Not covered	None

If you are pregnant	Office visits	20% after deductible	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% after deductible	Not covered	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services	20% after deductible	Not covered	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 needs	Home health care	20% after deductible	Not covered	- 120 visits per year - Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	20% after deductible	Not covered	- 60 visits per year (combined Physical, Occupational, Speech and Cognitive limits) - 20 visits per year for Chiropractic - Preauthorization may be required - if not obtained, penalty will be 50%
	Habilitation services	20% after deductible	Not covered	- 60 visits per year (combined Physical, Occupational, Speech and Cognitive limits) - 20 visits per year for Chiropractic - Preauthorization may be required - if not obtained, penalty will be 50%
	Skilled nursing care	20% after deductible	Not covered	- 120 days per year - Preauthorization may be required - if not obtained, penalty will be 50%.
	Durable medical equipment	20% after deductible	Not covered	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. - Preauthorization may be required - if not obtained, penalty will be 50%. - Wigs are covered at $500 per year
	Hospice services	20% after deductible	Not covered	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
- Dental Care
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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 Counseling and Treatment Artificial means to achieve pregnancy or ovulation is not a covered expense)

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 727-588-6136
- 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	$1,500
Specialist coinsurance	20%
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	$1,500
Copayments	$100
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
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	$1,000
Copayments	$2,500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$1,100
The total Joe would pay is	**$4,800**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
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	$1,500
Copayments	$0
Coinsurance	$400
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.