# HUMANA HEALTH PLAN, INC:
# Humana Basic 6600/Norton + Just for Kids HMOx

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: Beginning on or after 01/01/2015**

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

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.humana.com or by calling 1-800-833-6917.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$6,600 Individual /$13,200 Family.** Overall deductible doesn't apply to preventive care. Co-insurance and copayments don't count toward the deductible | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductible** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$6,600 Individual /$13,200 Family** | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, and health care this plan doesn't cover, Penalties. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See **www.humana.com or call 1-800-833-6917** for a list of Network **providers**<br>For Prescription Drugs: **Select Rx Network** (Wal-Mart and CVS) | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.** |
| **Do I need a referral to see a specialist?** | Yes. You need a referral to see a specialist. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. |

| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |
|---|---|---|

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No Charge after deductible | Not Covered | Allow 3 per calendar year with $35 copay/visit not subject to meeting deductible. |
| | Specialist visit | No Charge after deductible | Not Covered | ——————none—————— |
| | Other practitioner office visit | Chiropractor Exam: No Charge after deductible | Not Covered | 12 Visits per calendar year for Spinal manipulations, adjustments, modalities. |
| | Preventive care/ screening / immunization | No Charge | Not Covered | ——————none—————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge after deductible | Not Covered | Cost share may vary based on where service is performed. |
| | Imaging (CT/PET scans, MRIs) | No Charge after deductible | Not Covered | Preauthorization may be required, penalty will be $500.<br>Cost share may vary based on where service is performed. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.humana.com. | Generic and brand-named drugs | No Charge after deductible (Retail)<br>No Charge after deductible (Mail Order) | Not Covered | Preauthorization may be required, penalty will be 100% for certain prescription drugs.<br>30 day supply (Retail)<br>90 day supply (Mail Order) |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge after deductible | Not Covered | ——————none—————— |
| | Physician/surgeon fees | No Charge after deductible | Not Covered | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | No Charge after deductible | No Charge after deductible | ——————none—————— |
| | Emergency medical transportation | No Charge after deductible | No Charge after deductible | ——————none—————— |
| | Urgent care | No Charge after deductible | Not Covered | Cost share may vary based on where service is performed. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge after deductible | Not Covered | Preauthorization may be required, penalty will be $500. |
| | Physician/surgeon fee | No Charge after deductible | Not Covered | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No Charge after deductible | Not Covered | ——————none—————— |
| | Mental/Behavioral health inpatient services | No Charge after deductible | Not Covered | Preauthorization may be required, penalty will be $500. |
| | Substance use disorder outpatient services | No Charge after deductible | Not Covered | ——————none—————— |
| | Substance use disorder inpatient services | No Charge after deductible | Not Covered | Preauthorization may be required, penalty will be $500. |
| **If you are pregnant** | Prenatal and postnatal care | No Charge after deductible | Not Covered | ——————none—————— |
| | Delivery and all inpatient services | No Charge after deductible | Not Covered | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care | No Charge after deductible | Not Covered | Preauthorization may be required, penalty will be $500.<br>100 visits per calendar year. |
| | Rehabilitation services | No Charge after deductible | Not Covered | Preauthorization may be required, penalty will be $500.<br>20 separate visits for PT, OT, ST and RT per calendar year.<br>12 Visits per calendar year for Spinal manipulations, adjustments, modalities.<br>36 visits per calendar year for CT.<br>Any limits for Habilitation services and Rehabilitation services are combined. |
| | Habilitation services | No Charge after deductible | Not Covered | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Skilled nursing care | No Charge after deductible | Not Covered | Preauthorization may be required, penalty will be $500.<br>90 days per calendar year. |
| | Durable medical equipment | No Charge after deductible | Not Covered | Preauthorization may be required, penalty will be $500. |
| | Hospice service | No Charge | No Charge | Preauthorization may be required, penalty will be $500. |
| **If your child needs dental or eye care** | Eye exam | No Charge after deductible | Not Covered | 1 exam every 12 months. |
| | Glasses | No Charge after deductible | Not Covered | 1 pair of lenses and frame per year.<br>One additional, complete pair of eyeglasses (lenses & frame) if medically necessary. |
| | Dental check-up | Not Covered | Not Covered | ——————none—————— |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery for morbid obesity
- Cosmetic surgery, unless to correct a functional impairment caused by injury, infection, disease
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Dental Check Up (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care – spinal manipulations are covered
- Hearing Aids for children under 18
- Private-duty nursing (home health care visit)
- Routine eye care (Adult) when in treatment for diabetes
- Routine foot care when in treatment for diabetes

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium.** There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-833-6917. You may also contact your state insurance department at Department of Insurance, PO Box 517, Frankfort, KY 40602-0517, Phone: 502-564-3630 or 800-595-6053 or TTY: 800-648-6056.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Department of Insurance, PO Box 517, Frankfort, KY 40602-0517, Phone: 502-564-3630 or 800-595-6053 or TTY: 800-648-6056.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does not provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

*To see examples of how this plan might cover costs for a sample medical situation, see the next page*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,140
- **Patient pays** $6,400

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $6,400 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$6,400** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $340
- **Patient pays** $5,060

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $4,900 |
| Copays | $140 |
| Coinsurance | $0 |
| Limits or exclusions | $20 |
| **Total** | **$5,060** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.