HUMANA HEALTH PLAN, INC: Humana Silver 4600 (3250)/Norton + Just for Kids HMOx CSR level C

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

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

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?	**$3,250 Individual /$6,500 Family** Overall deductible doesn't apply to preventive care and prescription drugs. 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?	Yes. Prescription Drugs: **$1,000 Individual/$2,000 Family**. There are no other specific **deductibles.**	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.
Is there an out–of–pocket limit on my expenses?	Yes. **$4,750 Individual /$9,500 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** 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**.

Network: Norton + Just for Kids HMOx **Questions:** Call 1-800-833-6917 or visit us at www.humana.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-833-6917 to request a copy.

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	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	——————none——————
	Specialist visit	$35 copay/visit	Not Covered	——————none——————
	Other practitioner office visit	Chiropractor Exam: 20% coinsurance	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)	$500 per calendar year paid at 100%; thereafter subject to deductible and 20% coinsurance	Not Covered	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	$500 per calendar year paid at 100%; thereafter subject to deductible and 20% coinsurance	Not Covered	Preauthorization may be required, penalty will be $500. 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	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com.	Level 1 – Preferred/ low-cost generics	$10 copay (Retail) $20 copay (Mail Order)	Not Covered	Preauthorization may be required, penalty will be 100% for certain prescription drugs. 30 day supply (Retail) 90 day supply (Mail Order) Level 1 and 2 drugs are not subject to the prescription drug deductible.
	Level 2 – Non-preferred generic	$20 copay (Retail) $40 copay (Mail Order)	Not Covered	
	Level 3 – Preferred brands	$50 copay after deductible (Retail) $100 copay after deductible (Mail Order)	Not Covered	
	Level 4 – Non-preferred brands	50% coinsurance	Not Covered	
	Level 5 –Specialty drugs	50% coinsurance	Not Covered	Preauthorization required, penalty will be 100% for certain prescription drugs. 40% coinsurance when filled via a preferred network specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	——————none——————
	Physician/surgeon fees	20% coinsurance	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$50 copay/visit	Not Covered	Cost share may vary based on where service is performed.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Preauthorization may be required, penalty will be $500.
	Physician/surgeon fee	20% coinsurance	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	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Exam: $25 copay/visit. Other Outpatient: 20% coinsurance	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	Preauthorization may be required, penalty will be $500.
	Substance use disorder outpatient services	Office Exam: $25 copay/visit. Other Outpatient: 20% coinsurance	Not Covered	——————none——————
	Substance use disorder inpatient services	20% coinsurance	Not Covered	Preauthorization may be required, penalty will be $500.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not Covered	——————none——————
	Delivery and all inpatient services	20% coinsurance	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Preauthorization may be required, penalty will be $500. 100 visits per calendar year
	Rehabilitation services	Occupational and Physical Therapy: $25 copay/visit All Others: 20% coinsurance	Not Covered	Preauthorization may be required, penalty will be $500. 20 separate visits for PT, OT, ST and RT per calendar year. 12 Visits per calendar year for Spinal manipulations, adjustments, modalities. 36 visits per calendar year for CT. Any limits for Habilitation services and Rehabilitation services are combined.
	Habilitation services	Occupational and Physical Therapy: $25 copay/visit All Others: 20% coinsurance	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	Limitations & Exceptions
If your child needs dental or eye care	Skilled nursing care	20% coinsurance	Not Covered	Preauthorization may be required, penalty will be $500. 90 days per calendar year.
	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization may be required, penalty will be $500.
	Hospice service	No Charge	No Charge	Preauthorization may be required, penalty will be $500.
	Eye exam	50% coinsurance	Not Covered	1 exam every 12 months.
	Glasses	50% coinsurance	Not Covered	1 pair of lenses and frame per year. 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 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** $3,920
- **Patient pays** $3,620

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	$3,200
Copays	$20
Coinsurance	$400
Limits or exclusions	$0
Total	**$3,620**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,080
- **Patient pays** $1,320

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	$100
Copays	$1,200
Coinsurance	$0
Limits or exclusions	$20
Total	**$1,320**

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.