**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 by calling 1-513-732-7981.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network (PAR) **providers**: **$2,000** single/**$4,000** family. Out-of-Network (Non-PAR) **providers**: **$4,000** single/ **$8,000** family. **Ded** doesn't apply to PAR preventive care. **Coins** & **copays** don't apply to **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 **deductibles** 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. Medical: PAR **providers**: **$4,000** single/**$8,000** family; Non-PAR **providers**: **$8,000** single/**$16,000** family. Plan Maximum Out-of-Pocket PAR **providers**: **$6,250** single /**$12,500** family; Non-PAR **providers**: **NA**. | 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, penalties, Non-PAR **copays**, non-Humana Nat'l Transplant Network transplants, & health care this plan doesn't cover. | 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 for a list of PAR **providers**. | 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?** | No. You don't need a referral to see a **specialist**. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**. |



OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013 (corrected)

- **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 PAR **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 **copayment** | 40% after **deductible** | ——————none————— |
| | **Specialist** visit | $40 **copayment** | 40% after **deductible** | ——————none————— |
| | Other practitioner office visit:<br>-Chiropractic exams, manipulations & therapies<br>-Chiropractic lab & x-ray | $40 **copayment**<br><br>No charge | 40% after **deductible**<br><br>40% after **deductible** | Limited to 12 visits/calendar year. |
| | Preventive care/screening/immunization | No charge | 40% after **deductible** | Limited to 1 colonoscopy /calendar year regardless of diagnosis |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 40% after **deductible** | ——————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% after **deductible** | 40% after **deductible** | **Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only) |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating 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. | Level 1 – Low cost drugs<br>Retail (30 days)<br>Retail (90 days)<br>Mail (90 days) | <br>$10 **copayment**<br>$30 **copayment**<br>$20 **copayment** | PAR copay + 30% + the difference between the default rate and the Non-PAR pharmacy charge/Rx | - 30 day supply (retail).<br>- 90 day supply (mail only).<br>-Pharmacy **Out-of-pocket** PAR **providers**: **$3,500** single/**$7,000** family; Non-PAR **providers**: **NA**<br>- No charge for retail flu and pneumonia immunizations, drugs on the Women's Healthcare Drug List, HCR preventative medication in addition to Polio, DTaP, MMR, Tetanusand Zostavax Vaccine.<br>- If you request a brand-name drug and a generic is available, you will be responsible for the cost differential between the brand-name drug and the generic plus any applicable **copayments**.<br>- Some medications will require **prior authorization,** step therapy or may have dispensing limits. |
| | Level 2 – High cost drugs<br>Retail (30 days)<br>Retail (90 days)<br>Mail (90 days) | <br>$40 **copayment**<br>$120 **copayment**<br>$80 **copayment** | | |
| | Level 3 - Higher cost drugs<br>Retail (30 days)<br>Retail (90 days)<br>Mail (90 days) | <br>$60 **copayment**<br>$180 **copayment**<br>$120 **copayment** | | |
| | Level 4 - Highest cost drugs<br>Retail (30 days)<br>Retail (90 days)<br>Mail (90 days) | <br>25% max $250<br>25% max $750<br>25% max $500 | | |
| | Specialty drugs:<br>- Obtained at a pharmacy<br>- Obtained by a qualified practitioner through Specialty Rx and administered in their office<br>- Obtained under medical benefits | <br>Same as Level 1, 2, 3 or 4<br>No charge<br><br><br>Medical benefits apply | <br>Same as Level 1, 2, 3 or 4<br>Not covered<br><br><br>Medical benefits apply | Self-administered specialty drugs are limited to a 30 day supply at Humana's preferred specialty vendor. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% after **deductible** | 40% after **deductible** | **Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only) |
| | Physician/surgeon fees | 20% after **deductible** | 40% after **deductible** | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $300 **copayment** | $300 **copayment** | **Copayment** waived if admitted inpatient |
| | **Emergency medical transportation** | No charge | No charge | ——————none———— |
| | **Urgent care** | $35 **copayment** | 40% after **deductible** | ——————none———— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% after **deductible** | 40% after **deductible** | **Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only) |
| | Physician/surgeon fee | 20% after **deductible** | 40% after **deductible** | ——————none———— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $20 **copayment** | 40% after **deductible** | ——————none———— |
| | Mental/Behavioral health inpatient services | 20% after **deductible** | 40% after **deductible** | **Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only) |
| | Substance use disorder outpatient services | $20 **copayment** | 40% after **deductible** | ——————none———— |
| | Substance use disorder inpatient services | 20% after **deductible** | 40% after **deductible** | **Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only) |
| **If you are pregnant** | Prenatal and postnatal care | 20% after **deductible** | 40% after **deductible** | ——————none———— |
| | Delivery and all inpatient services | 20% after **deductible** | 40% after **deductible** | ——————none———— |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | **Home health care** | 20% after **deductible** | 40% after **deductible** | Limited to 60 visits/calendar year<br>**Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only) |
| | **Rehabilitation services** | $20 **copayment** | 40% after **deductible** | Speech and Cognitive therapies limited to 60 visits/ calendar year<br>Physical and Occupational Therapies limited to 60 visits per year<br>Cardiac Rehab Phase II limited to 36 visits/calendar year<br>**Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only) |
| | **Habilitation services** | $20 **copayment** | 40% after **deductible** | |
| | **Skilled nursing care** | 20% after **deductible** | 40% after **deductible** | **Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only)<br>Limited to 120 days/calendar year. |
| | **Durable medical equipment** | 20% after **deductible** | 40% after **deductible** | **Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only)<br>Wigs are covered with no charge to the member. There is a $500 limit per every 3 years. |
| | **Hospice service** | No Charge | No Charge | **Prior authorization** is required. Failure to do so will reduce **coins** to 50% (Non-PAR only) |
| **If your child needs dental or eye care** | Eye exam | No Charge | 40% after deductible | Limited to 1 exam & 1 refraction/ calendar year<br>Refraction - $20 **copay** in an office visit setting and 20% after **deductible** in an outpatient setting |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Glasses | Not covered | Not covered | No coverage for glasses. |
| | Dental check-up | Not covered | Not covered | No coverage for dental check-ups. |

## 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.)**

- Behavioral health half-way house services
- Dental care (adult and child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Vision therapy
- 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.)**

- Acupuncture (limited to 12 visits/calendar year)
- Chiropractic care (limited to 12 visits/ year)
- Cosmetic surgery (Requires **prior auth**. Services will only be considered if due to a bodily injury or illness and functional impairment is present.)
- Dependent daughter maternity
- Routine eye care (adult and child)-Limited to one examination and one refraction/calendar year

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-513-732-7981. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or www.cciio.cms.gov.

## 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 Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

## 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** $4,590
- **Patient pays** $2,950

**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 | $2,000 |
| Copays | $20 |
| Coinsurance | $900 |
| Limits or exclusions | $30 |
| **Total** | **$2,950** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,380
- **Patient pays** $3,020

**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 | $2,000 |
| Copays | $ 1,000 |
| Coinsurance | $0 |
| Limits or exclusions | $20 |
| **Total** | **$3,020 ,** |

# 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.

**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.

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- 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.

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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’dę́ę́’, t’áá jiik’eh, éí ná hólǫ́, 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**).