HUMANA HEALTH PLAN, INC:
Humana Connect Silver 4600/6300 Plan

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

Coverage Period: Beginning on or after 01/01/2014
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?	**$4,600 Individual /$9,200 Family** 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. **$1,500 Individual/$3,000 Family** for prescription drug coverage. There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductibles** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,300 Individual /$12,600 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**	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-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.**

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

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 a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-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 Network Provider	Your Cost If You Use an Non-network Provider	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: 20% coinsurance	Not Covered	Chiropractor: 20 visits per calendar year
	Preventive care/screening/immunization	No Charge	Not Covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge for the first $500 then 20% coinsurance	Not Covered	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Cost share may vary based on where service is performed.

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	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	30 day supply (Retail) 90 day supply (Mail Order)
	Level 2 – Nonpreferred generic	$20 copay (Retail) $40 copay (Mail Order)	Not Covered	See Level 1 for Limitations and Exceptions
	Level 3 – Preferred brands	$50 copay (Retail) $100 copay (Mail Order)	Not Covered	See Level 1 for Limitations and Exceptions
	Level 4 – Nonpreferred brands	50% coinsurance	Not Covered	See Level 1 for Limitations and Exceptions
	Level 5 –Specialty drugs	50% coinsurance	Not Covered	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	——————none——————
	Physician/surgeon fee	20% coinsurance	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an Network Provider	Your Cost If You Use an Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	——————none——————
	Substance use disorder outpatient services	20% coinsurance	Not Covered	——————none——————
	Substance use disorder inpatient services	20% coinsurance	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not Covered	Cost share may vary based on where service is performed
	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	——————none——————
	Rehabilitation services	20% coinsurance	Not Covered	60 combined Physical, Occupational, Speech, Cognitive, Audiology, Cardiac and Respiratory Therapy visits per calendar year.
	Habilitation services	20% coinsurance	Not Covered	60 combined Physical, Occupational, Speech, Cognitive, Audiology, Cardiac and Respiratory Therapy visits per calendar year.
	Skilled nursing care	20% coinsurance	Not Covered	90 days per calendar year.
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice service	20% coinsurance	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	50% coinsurance	Not Covered	——————none——————
	Glasses	50% coinsurance	Not Covered	——————none——————
	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
- 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.)**

- Bariatric surgery
- Chiropractic care – spinal manipulations are covered
- Hearing Aids
- Private-duty Nursing – inpatient when skill nursing facility is not available
- 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, 2910 North 44th Street, Suite 210, Phoenix, AZ 85018-7269, Phone: 602-364-2499 or 800-325-2584 or Spanish: 602-364-2977.

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, 2910 North 44th Street, Suite 210, Phoenix, AZ 85018-7269, Phone: 602-364-2499 or 800-325-2584 or Spanish: 602-364-2977.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-833-6917
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-833-6917

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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **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** $2,493.07
- **Patient pays** $5,046.93

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	$4,600.00
Copays	$15.21
Coinsurance	$431.72
Limits or exclusions	$0.00
Total	**$5,046.93**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,082.74
- **Patient pays** $ 1,317.26

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	$129.00
Copays	$1,170.20
Coinsurance	$0.00
Limits or exclusions	$18.06
Total	**$1,317.26**

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.