Summary of Benefits and Coverage (SBC) overview

The SBC document gives you a snapshot of your plan, with the deductibles, out-of-pocket costs, pharmacy coverage and your cost share explained.

It also answers common questions you might have about your health plan.

The summary is divided into three sections:

1. Important questions

- Overall deductible
- Additional deductibles, such as pharmacy
- Out-of-pocket limits
- Use of a network
- Referral necessity

2. Common medical events

- Office visit copays
- Preventive screenings
- Diagnostic testing
- Prescription drug coverage
- Outpatient surgery
- Urgent care, emergency and hospital care
- Behavioral health
- Limitations and exceptions

3. Excluded services and other covered services

- A partial list of common services showing what's included and what's not included in your plan.

HUMANA INSURANCE COMPANY: KS LEHD D/C 14
Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage Period: 01/01/2014-12/31/2014
Coverage For: Individual + Family | **Plan Type:** PPO-HDHP

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 1-866-4ASSIST (427-7478).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$5,000 Individual / $10,000 Family** Non-Network: **$15,000 Individual / $30,000 Family** Doesn't apply to preventive services. Co-insurance and co-payments 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 3 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 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses	Yes. For Network providers **$6,000 Individual / $12,000 Family** For Non-Network providers **$18,000 Individual / $36,000 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, Health care this plan doesn't cover, Penalties, Non-network transplant	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 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a 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	20% coinsurance	50% coinsurance	——————none——————
	Specialist visit	20% coinsurance	50% coinsurance	——————none——————
	Other practitioner office visit	Chiropractor: 20% coinsurance	Chiropractor: 50% coinsurance	Chiropractor: 30 PT,OT,ST,CT, AT visit limit per year includes manips & adjustments For non-network, 10 PT,OT,CT,ST,AT visits per year includes manips & adjustments
	Preventive care / screening / immunization / endoscopic / preventive care (child) / screening (child) / immunizations (child)	No Charge	30% coinsurance	limited coverage for preventive care
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization may be required, penalty may apply Cost share may vary based on where service is performed
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.humana.com.**	Generic and brand-name drugs	20% coinsurance (Retail) 20% coinsurance (Mail Order)	50% coinsurance (Retail) 50% coinsurance (Mail Order)	Preauthorization may be required, penalties may apply. 30 day supply (Retail) 90 day supply (Mail Order)

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
- Child dental check-up
- Child eye exam
- Child glasses
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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

Ask your company's benefits administrator or call us at 1-866-4ASSIST (427-7478) to obtain a copy of your SBC.

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The format of the Summary of Benefits and Coverage cannot be edited, revised or changed in any manner as the format is established by the U.S. Federal Government and its agencies. The above SBC is an example for illustration only.

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- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- 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**.

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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**

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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'dęę', t'áá jiik'eh, éí ná hóló, 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)**.

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