

Humana Platinum 500/Phoenix HMOx

About this plan

Humana Platinum 500/Phoenix HMOx is a Health Maintenance Organization (HMO) health plan. You must choose a primary care physician (PCP) from our local network of healthcare providers who will refer you to in-network specialists or hospitals when necessary.

- › This plan is a Qualified Health Plan offered by Humana Health Plan, Inc.
- › This plan covers inpatient and outpatient medical services, and includes prescription drug coverage. It also provides all preventive services and includes most essential health benefits, like maternity and childbirth. It does not include children's dental. Talk with your agent to learn about the Humana Dental Smart Choice Plan for children. Information can also be found at **Humana.com** or on the Health Insurance Marketplace (also known as "Exchange").

Selecting a PCP – When you apply for an HMO plan, you must select an in-network PCP who will be your first point of contact for healthcare. Together, you and your PCP can make the best decisions to manage your health and well-being, which includes your PCP making referrals to other in-network specialists.

- › To search for a PCP in your area, visit **Humana.com/FindADoctor**. Use your plan's network name to locate a PCP close to home.
- The network name is **Phoenix HMOx**

The pharmacy network – The pharmacy network name is **"Select Rx Network."** CVS, Walmart and Sam's Club pharmacies are retail pharmacies in the network. This plan also gives you access to Humana's prescription mail delivery service, Humana Pharmacy®. Visit **HumanaPharmacy.com** to learn more.

- › To find an in-network pharmacy near you, visit **Humana.com/PharmacyLocator**.

Who can apply for this plan – Any individual or family can apply for this plan. There are three requirements: You must live in the U.S., you must be a U.S. citizen or national (or lawfully present), and you cannot be currently incarcerated. (**healthcare.gov**)

Congratulations!

When you enroll in this plan you have access to HumanaVitality® – a wellness and rewards program for everyone, no matter your age or health status. Making small changes in your everyday life can add up to healthy long-term rewards – and can save you up to \$600 a year on Great For You™ healthier food purchases at Walmart.®

Start by taking a short Health Assessment that focuses on your daily routines – and then let HumanaVitality help lead you on a path to better health by receiving personalized goals and activity recommendation that can help you earn rewards and make healthier choices. Visit **HumanaVitality.com** to learn more.

This plan is available in the following county: Maricopa

Humana®



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Date the plan starts – The initial Open Enrollment period for 2016 coverage is November 1, 2015 to January 31, 2016. Coverage can start as early as January 1, 2016. After Open Enrollment you can enroll in individual or family coverage if you have a qualifying life event. Examples of qualifying life events are moving to a new state, certain changes in your income and changes to your family size (e.g. if you marry, divorce or have a baby). (healthcare.gov)

Out-of-network coverage – There is no coverage for out-of-network healthcare providers except for emergency care as defined in your contract. In addition, if you fill your prescriptions at a retail pharmacy other than CVS, Walmart or Sam's Club, or use a mail order service other than **HumanaPharmacy.com**, there is no coverage, except in an emergency as defined in your contract.

Insurance terms you should know:

Coinsurance – A percentage of your medical and drug costs that you pay out of your pocket

Copay – The fixed dollar amount you pay when you receive medical services or have a prescription filled

Deductible – The amount you pay for medical services or prescriptions before your plan pays for your benefits

Network – A group of healthcare providers or pharmacies who are contracted with Humana to provide medical services or prescription drugs at a discounted rate; often referred to as “in-network”

Maximum out-of-pocket – The most you could pay toward covered expenses including deductibles, copays and coinsurance

This document is for information only and contains a general summary of covered benefits, exclusions, and limitations. Please refer to the plan's medical insurance contract for a full list of benefits covered.

The medical insurance contract is a document that details the benefits and provisions of the plan, as well as limitations and services that are not covered. Please see the “Limitations and exclusions” that are included in this document. If there are discrepancies with the information given in this document, the terms and conditions of the medical insurance contract will apply.

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		In-network	
		Individual	Family
Combined medical and children's vision care deductible*	The amount of covered expenses you'll pay out of your pocket before the plan pays for covered services	\$500	\$1,000
Annual out-of-pocket maximum*	The most you pay toward the covered cost of your health care for the calendar year; includes copays, deductibles, coinsurance and pharmacy charges; does not include the premium › Once you reach your out-of-pocket maximum, the plan pays 100% of all covered expenses › Copays do not accumulate toward the deductible but they do accumulate to the out-of-pocket maximum › Deductible and out-of-pocket maximum start over each new calendar year	\$1,500	\$3,000
Coinsurance*	The percentage you pay for covered in-network medical services	You pay 20% of covered expenses after you pay your deductible	
* If your family is covered, the individual deductible and out-of-pocket maximum accumulate to the medical and prescription drug individual and family maximum. An individual covered family member will receive coinsurance benefits once they have met their individual deductible. The rest of the covered family members will receive coinsurance benefits once they have satisfied their individual deductible or when the entire family deductible has been satisfied.			
Lifetime maximum	The total amount this plan will pay for covered expenses in your lifetime	Unlimited	
Preventive care	Includes preventive office visits, lab tests, X-rays, child immunizations, flu and pneumonia immunizations, Pap tests, mammograms, prostate screening, certain endoscopic services and more › A PCP referral is not required for in-network OB/GYN services	This plan pays 100%	
Diagnostic visits	Includes, but is not limited to, maternity and mental health services › A PCP referral is not required for in-network Chiropractors, for the first 12 visits per calendar year To search for a Primary Care Physician (PCP), Retail Clinic, Urgent Care or Specialist, go to Humana.com/FindADoctor . Use the plan's network name to locate a provider close to home. The network name for this plan is Phoenix HMOx	This plan pays 100% after you pay a copay per visit: • \$20 for PCP • \$30 for retail clinic • \$40 for urgent care • \$40 for specialist	
Diagnostic lab and X-rays	› Includes allergy testing › Includes maternity and mental health services › Advanced imaging, pulmonary function studies, cardiac catheterization, EKG, ECG and EEG	The plan pays 100% of the first \$500 per covered plan member per calendar year; then you pay 20% after you pay your deductible You pay 20% after you pay your deductible	

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In-network		
Emergency room	<p>Emergencies are life-threatening illnesses or injuries</p> <ul style="list-style-type: none"> › Includes, but is not limited to, major head trauma, chest pain, severe abdominal pain, loss of consciousness, amputation of a body part, severe break or bone fracture and signs or symptoms of stroke or heart attack <p>Non-emergency emergency room visits</p> <ul style="list-style-type: none"> › Costs incurred will not apply toward your deductible or maximum out-of-pocket 	<p>\$250 copay per visit then you pay 20% after you pay your deductible</p> <p>Not covered</p>
Ambulance		You pay 20% after you pay your deductible
Hospital stay	<p>Inpatient</p> <ul style="list-style-type: none"> › Facility fee (e.g. hospital room) › Physician/surgeon fees <p>Outpatient</p> <ul style="list-style-type: none"> › Facility fee (e.g. ambulatory surgery center) › Physician/surgeon fees 	You pay 20% after you pay your deductible
Maternity	Delivery and related inpatient and outpatient services	You pay 20% after you pay your deductible
Transplants	Benefits must be received from a Humana National Transplant Network provider	You pay 20% after you pay your deductible
Mental health	<p>Mental illness and chemical/alcohol dependency</p> <ul style="list-style-type: none"> › Includes inpatient and outpatient services 	You pay 20% after you pay your deductible
Durable medical equipment	<p>Items that are prescribed by a healthcare provider for use in a patient's home. Including, but not limited to:</p> <ul style="list-style-type: none"> › Hospital beds › Nebulizers › Oxygen Equipment › Wheelchairs 	You pay 20% after you pay your deductible
Other medical services	<p>Including, but not limited to:</p> <ul style="list-style-type: none"> › Skilled nursing facility – up to 90 days per calendar year › Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – combined, up to 60 visits per calendar year for services related to rehabilitation. › Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – combined, up to 60 visits per calendar year for services related to habilitation. › Spinal manipulations, adjustments, and modalities – 12 visits without referral and an additional 8 visits allowed per calendar year (for a total of 20 visits) › Home healthcare services › Hospice Care › Hearing Exam – 1 per calendar year › Hearing Aid – 1 per ear per calendar year 	<p>You pay 20% after you pay your deductible</p> <p>Benefit level is based upon the place of treatment (Inpatient, Outpatient, Clinic location)</p>

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In-network		
Prescription drugs	<p>The pharmacy network name is “Select Rx Network”</p> <ul style="list-style-type: none"> › Prescriptions must be filled at in-network pharmacies; if you use an out-of-network pharmacy, there is no coverage except in the case of an emergency › In-network retail pharmacies are CVS, Walmart and Sam’s Club pharmacies › You pay a copay or a portion of the drug cost for each covered prescription fill or refill up to a 30-day supply at these in-network pharmacies › You do not need to be a member of Sam’s Club to have your prescription filled at Sam’s Club pharmacies › This plan also gives you access to Humana’s prescription mail delivery service, Humana Pharmacy <ul style="list-style-type: none"> • Visit HumanaPharmacy.com to learn more • Mail delivery through Humana Pharmacy covers up to a 90 day supply at 2.5 times the retail copay › The prescription drug plan name is Rx5 Plus <ul style="list-style-type: none"> • Use the Rx drug list search tool at Humana.com/DrugLookup to find out what drugs are included; or • Visit www.humana.com/2016-Rx5-Plus for a comprehensive listing of covered drugs 	<p>Level 1</p> <ul style="list-style-type: none"> • \$5 copay for covered preferred generic drugs <p>Level 2</p> <ul style="list-style-type: none"> • \$10 copay for covered non-preferred generic drugs <p>Level 3</p> <ul style="list-style-type: none"> • \$20 copay for covered preferred brand name drugs <p>Level 4</p> <ul style="list-style-type: none"> • 35% coinsurance for covered non-preferred brand name drugs <p>Level 5</p> <ul style="list-style-type: none"> • 35% coinsurance for covered specialty drugs* <p>* Some specialty drugs are 25% when purchased from a preferred network specialty drug pharmacy like Humana Specialty Pharmacy</p>
Children’s vision care	<p>Children are covered though age 19</p> <ul style="list-style-type: none"> › Exam with dilation as necessary (limit 1 per year) › Medically necessary eyeglass lenses with covered frames or contact lenses (limit 1 per year) <ul style="list-style-type: none"> • Eyeglass lens options – standard polycarbonate and/or standard scratch coating › Low vision <ul style="list-style-type: none"> • Supplemental testing (limit 1 every 2 years) › Vision aids (limit 1 every 3 years) <ul style="list-style-type: none"> • Video magnification aids (1 every 5 years) › If you buy a frame outside of the selection, the plan provides a benefit up to the amount that would have been paid if you chose a frame from the selection; additional discounts may be available with network providers › The above services are not all inclusive; see the plan contract for more details 	<p>You pay 50% after you pay your deductible</p>

Health Insurance Marketplace

- › If coverage was purchased through the Health Insurance Marketplace and an Advance Premium Tax credit was received, any deductible, copay, coinsurance and/or out-of-pocket coinsurance maximum may change without notice. The Health Insurance Marketplace will determine if a change is to be made. We will make the change as directed.

Network agreements

Network providers (also called in-network providers) agree to accept an agreed-upon amount as payment in full. Your contract explains your share of the cost of services rendered by network providers. The plan may include a deductible, a set amount (copay), and a percent of the costs (coinsurance).

When you go to an in-network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay for health benefits is based on Humana's net charges.
- The amount you pay for dental and vision benefits is based on Humana's net charges.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana individual health plan listed above. It is designed for convenient reference. Consult the contract for a complete list of limitations and exclusions. Certain medical services require preauthorization before services are rendered. Certain prescription drugs, including specialty drugs, require prior authorization and may also require step therapy. Please visit [humana.com/individual-and-family](https://www.humana.com/individual-and-family) for a detailed list. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and billing exclusions

- Services provided by a family member or person who resides with the covered person.
- Services incurred before the effective date, after the termination date, or when premium is past due.
- Charges in excess of the default rate.
- Charges in excess of any benefit maximum.
- Services not authorized, furnished, or prescribed by a healthcare provider.
- Services for which no charge is made.
- Services which are not rendered by the billing provider.
- Services which are not substantiated in the medical records by the billing provider.
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary.
- Services not medically necessary, or that do not meet our medical and pharmacy coverage policies, claim payment policies or benefit contract guidelines except for routine preventive medical services as stated in the contract.
- Services that require referral from a primary care physician (PCP) if the referral was not obtained or was not approved or authorized by us prior to the service being rendered other than an in-network urgent care center or an in-network retail clinic.

Elective and cosmetic services

- Cosmetic services, or any related complication.
- Elective medical or surgical procedures except elective tubal ligation and vasectomy.
- Hair prosthesis, hair transplants, or hair implants.
- Prophylactic services other than a prophylactic mastectomy.

Immunizations

- Immunizations except as stated in the contract.

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury and certain oral surgical procedures), appliances, or supplies.
- Foot care services.
- Hearing care that is routine except as stated in the contract; any artificial hearing device, cochlear implants, auditory prostheses or other means of auditory comprehension except as stated in the contract.
- Vision examinations or testing, eyeglasses, contact lenses, eye exercises, or any surgery or procedure to change or correct vision except as stated in the contract.

Pregnancy and sexuality services

- Elective medical or surgical abortion except as stated in the contract.
- Immunotherapy for recurrent abortion.

- Home uterine activity monitoring.
- Reversal of sterilization.
- Infertility services, except as stated in the contract.
- Sex change services and sexual dysfunction.
- Services rendered in a premenstrual syndrome or holistic medicine clinic.

Illness/injury circumstances

- Expenses incurred for a sickness or bodily injury arising out of, or in the course of, any employment for wage or profit if the covered person is insured or is required to be insured by Workers' Compensation.
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, being intoxicated or under the Influence of an Illegal narcotic or a controlled substance, unless the condition is reported as a result of mental illness or chemical dependency.

Care in certain settings

- Private duty nursing except as stated in the contract.
- Custodial or maintenance care.
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service connected sickness or bodily injury.

Hospital services

- Pre-surgical/procedural testing duplicated during a hospital confinement.
- Services received in an emergency room unless required because of emergency care.
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.
- Hospital inpatient services, including physician services, when the covered person is in observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health.

Mental health services

- Court-ordered mental health services unless medically necessary.
- Services and supplies that are rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services.
- Services and supplies that extend beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.

Other payment available

- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law.
- Charges for which any other insurance providing medical payments exists.

Services not considered medical

- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner.

Other

- Any expense incurred for services received outside of the United States except as required by law for emergency care services.
- Biliary lithotripsy; Chemonucleolysis.
- Charges for growth hormones except as stated in the contract.
- Contraceptives when prescribed for purposes other than to prevent pregnancy.
- Educational or vocational training or therapy, services, and schools.
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations.
- Genetic testing, counseling, or services except for BRCA screening, counseling, and testing recommended by the HRSA or unless medically necessary for the purpose of determining an appropriate course of treatment.
- Hyperhidrosis.
- Immunotherapy for food allergy.
- Light treatment for Seasonal Affective Disorder (S.A.D.).
- Living expenses, travel, transportation, except as stated in the contract.
- Prolotherapy; Sensory integration therapy.
- Services for care or treatment of non-covered procedures, or any related complication.
- Alternative medicine including but not limited to holistic medicine and naturopathy.
- Services that are experimental, investigational, or for research purposes.
- Sleep therapy.
- Treatment for CMJ or any jaw joint problem except as stated in the contract.
- Treatment of nicotine habit or addiction except for smoking cessation aids, prescription and over the counter drugs with a prescription from a healthcare practitioner and interventions for tobacco use.

- Any drug and/or ingredient which is not FDA approved including bulk compounding ingredients.
- Legend drugs not recommended or deemed necessary by us or drugs prescribed for a non-covered bodily injury or sickness.
- Drugs prescribed for intended use other than for indications approved by the FDA or recognized off label indications through peer reviewed medical literature.
- Prescription fills or refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
- Vitamins, herbs, minerals, dietary supplements, nutritional products, and any other nonprescription supplements except for the treatment of inherited metabolic disease or amino acid-based formulas for the treatment of eosinophilic gastrointestinal disorder.
- Over the counter medical items, supplies, or drugs that are available without a prescription except for insulin or drugs on our Preventive Medication Coverage drug list.
- Prescription fills or refills that exceed our drug or dispensing specific limits or are refilled early.
- Drugs for which step therapy is required if step therapy was not obtained from us.
- Anorectic or any drug used for weight control, abortifacients, allergen extracts, or any drug not included on our drug list.
- Costs related to mailing, sending or delivery of a drug or drugs that are lost, stolen, spilled, spoiled or damaged.
- Prescription drugs filled at an out-of-network pharmacy.

Additional expenses not covered for the following benefits:

Pediatric Vision

- Orthoptic or vision training and any associated testing.
- Multiple pair of glasses in lieu of bifocals or trifocals.
- Pre-and post-operative services; medical or surgical treatment of the eye(s) or supporting structure.
- Services or materials required by an employer; safety lenses and frames.
- Contact lenses when benefits are paid for frames and lenses.
- Separate fees for pre and post-operative services.
- Oversized 61 and above lens or lenses; artistically painted lenses; premium lens options.
- Treatment related to or caused by disease.
- Charges for missed appointments or completion of claim forms.
- Non-prescription materials or vision devices.
- Costs for securing materials; routine maintenance of materials.
- Refitting or change in lens design after initial fitting.
- Orthokeratology.
- Services provide by an out-of-network provider.
- Vision care not obtained from an in-network provider designated by us.

Pediatric Dental

- Charges for precision or semi-precision attachments, overdentures and any associated endodontic treatment, any customized attachments, temporary and interim dental services, charges related to materials or equipment used in delivery of dental care, or services for 3D imaging (cone beam images).
- Orthognathic surgery except as stated in the contract; destruction of lesions; tooth transplantation; removal of a foreign body from the oral tissue or bone; reconstruction of facial bones.
- Implants and any related services except as stated in the contract.
- Elective removal of non-pathologic impacted teeth; replacement of fillings in place less than two years.
- Infection control including but not limited to sterilization techniques.
- Charges for missed appointments or completion of claim forms.
- Charges related to altering vertical dimension of teeth or changing the spacing and/or shape of the teeth, restoration or maintenance of occlusion, splinting teeth, including multiple abutments or any service to stabilize periodontally weakened teeth, replacing tooth structures lost resulting from abrasion, attrition, erosion or abfraction, or bite registration or analysis.
- Hospital, surgical or treatment facility or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-mediations.
- Orthodontic services or repair and replacement of orthodontic appliances except as stated in the contract.
- Preventive control programs including but not limited to oral hygiene instructions, plaque control, take-home items, or dietary planning.
- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Services performed by other than a dentist except as stated in the contract.
- Services not eligible for benefits based on a clinical review, does not offer a favorable prognosis, or does not have uniform professional acceptance.
- Services provide by an out-of-network provider.

Offered by Humana Health Plan, Inc. Applications are subject to eligibility requirements. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage call or write your Humana insurance agent or broker.

Add Humana Dental Smart Choice to protect a healthy smile

The following dental contract is available to you at an extra cost

Make your Humana plan fit your needs even better. This extra benefit is an easy and affordable way to get the coverage you need.

Dental

Good health starts with a healthy mouth. You can protect your healthy smile with cost-effective, easy-to-use dental benefits from one of the nation's largest dental insurers. Regular dental exams and cleanings can lower the risk of gum disease, which is linked to heart disease, diabetes, stroke, and other serious conditions.

The Humana Dental Smart Choice plan is designed for individuals and families who believe in the importance of regular dental care. With no office visit copays for diagnostic and preventive services, the plan offers immediate and affordable benefits for children; for adults, there is a 6 month waiting period for basic services. Children, through the age of 19, can be covered under an individual or family contract and no one will be turned away from pre-existing conditions. The plan is a Qualified Dental Health Plan in the Health Insurance Marketplace and your plan year starts with the first month of eligibility.

More than 225,000 dentist locations are included in the Humana Dental PPO network. To find dentists in your area, visit **Humana.com**.

These plans have limitations and exclusions, waiting periods, and terms under which the plans may be continued in force or discontinued.

For more information, go to Humana.com or contact your sales agent.

Insured or offered by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, The Dental Concern, Inc., CompBenefits Insurance Company, CompBenefits Company, CompBenefits Dental, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Benefit Plan of Louisiana, Inc., DentiCare, Inc. (d/b/a CompBenefits), Discount plans offered by HumanaDental Insurance Company, Humana Insurance Company or Texas Dental Plans, Inc.

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