Humana Insurance Company
Humana Bronze 6150/ChoiceCare PPO

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO

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 http://apps.humana.com/marketing/documents.asp?file=2887963 or by calling **1-800-833-6917**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$6,150 Individual / $12,300 Family** Out-of-network: **$12,300 Individual / $24,600 Family** Doesn't apply to preventive care. Coinsurance 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: In-network: **$1,000 Individual / $2,000 Family** Out-of-network: **Does not apply** 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. In-network: **$7,150 Individual / $14,300 Family** Out-of-network: **Does not apply**	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 and 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 or call **1-800-833-6917** for a list of Network **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**.

Questions: Call 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 **800-833-6917** to request a copy.

Important Questions	Answers	Why this Matters:
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 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 in-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 Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	70% coinsurance after deductible	3 combined visit limit for all mental health, PCP, specialist, and retail clinic per person per calendar year at copay level; thereafter subject to medical deductible and coinsurance.
	Specialist visit	$40 copay/visit	70% coinsurance after deductible	
	Other practitioner office visit	Chiropractor Exam: 20% coinsurance after deductible	70% coinsurance after deductible	---none---
	Preventive care/ screening/immunization	No charge	Not covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	70% coinsurance after deductible	Preauthorization may be required. Penalty will be $500.

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 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/2017-Rx4-EHB or click here	Level 1 - Preferred, lowest cost generics	$15 copay (Retail) $45 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) Specialty drugs are not covered under the 90 day mail order benefit. Deductible does not apply to level 1 or 2 drugs.
	Level 2 - Low cost generic drugs	$35 copay (Retail) $105 copay (Mail order)	Not covered	
	Level 3 - Preferred brands drugs and some higher cost generic drugs	$75 copay (Retail) $225 copay (Mail order)	Not covered	
	Level 4 - Brand drugs and some non-preferred highest cost generic drugs	50% coinsurance	Not covered	
	Specialty drugs	50% coinsurance	Not covered	**Specialty Drugs:** 40% coinsurance when filled via a preferred network pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	70% coinsurance after deductible	Preauthorization may be required. Penalty will be $500.
	Physician/surgeon fees	20% coinsurance after deductible	70% coinsurance after deductible	Preauthorization may be required. Penalty will be $500.
If you need immediate medical attention	Emergency room services	$600 copay per visit and deductible	$600 copay per visit and deductible	---none---
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	---none---
	Urgent care	Not covered	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	70% coinsurance after deductible	Preauthorization may be required. Penalty will be $500.
	Physician/surgeon fee	20% coinsurance after deductible	70% coinsurance after deductible	---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 Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/office visit and 20% coinsurance after deductible for other outpatient services	70% coinsurance after deductible	3 combined visit limit for all mental health , PCP, specialist, and retail clinic and PCP per person per calendar year at copay level; thereafter subject to medical deductible and coinsurance.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	70% coinsurance after deductible	Preauthorization may be required. Penalty will be $500.
	Substance use disorder outpatient services	$20 copay/office visit and 20% coinsurance after deductible for other outpatient services	70% coinsurance after deductible	3 combined visit limit for all mental health , PCP, specialist, and retail clinic and PCP per person per calendar year at copay level; thereafter subject to medical deductible and coinsurance.
	Substance use disorder inpatient services	20% coinsurance after deductible	70% coinsurance after deductible	Preauthorization may be required. Penalty will be $500.
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	70% coinsurance after deductible	---none---
	Delivery and all inpatient services	20% coinsurance after deductible	70% coinsurance after deductible	Preauthorization may be required. Penalty will be $500.
If you need help recovering or have other special health needs	Home health care	0% for the first 10 visits, then subject to applicable coinsurance per person per calendar year	Not covered	Preauthorization may be required. Penalty will be $500.
	Rehabilitation services	20% coinsurance after deductible	Not covered	Preauthorization may be required. Penalty will be $500. 20 combined visits for Spinal manipulations, modalities, and adjustments and Physical and Occupational Therapy per calendar year. 20 visits for Speech Therapy per calendar year. 36 visits for Cardiac Therapy per calendar year.
	Habilitation services	20% coinsurance after deductible	Not covered	
	Skilled nursing care	20% coinsurance after deductible	Not covered	Preauthorization may be required. Penalty will be $500. 30 days per year.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Preauthorization may be required. Penalty will be $500.
	Hospice service	20% coinsurance after deductible	Not covered	Preauthorization may be required. Penalty will be $500.

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 Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	50% coinsurance after deductible	50% coinsurance after deductible	1 exam per year.
	Glasses	50% coinsurance after deductible	50% coinsurance after deductible	1 pair of glasses/frames per year.
	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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (home health 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
- 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 800-833-6917. You may also contact your state insurance department at Mississippi Insurance Department, PO Box 79, Jackson, MS 39205-0079 - Phone: 601-359-3569 or 800-562-2957 - Website: www.mid.ms.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 your state insurance department at Mississippi Insurance Department, PO Box 79, Jackson, MS 39205-0079 - Phone: 601-359-3569 or 800-562-2957 - Website: www.mid.ms.gov.

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-833-6917.

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** $1,140
- **Patient pays** $6,400

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	$6,150
Copays	$20
Coinsurance	$200
Limits or exclusions	$30
Total	**$6,400**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,500
- **Patient pays** $2,900

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	$2,100
Copays	$700
Coinsurance	$0
Limits or exclusions	$100
Total	**$2,900**

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 the 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.

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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)**.

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).**

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):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-320-1235 (رقم هاتف الصم والبكم: 711).**

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)**