

# HUMANA HEALTH PLAN OF TEXAS:

## Humana Connect Platinum 0/1500 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 contract or plan document at [www.humana.com](http://www.humana.com) or by calling 1-800-833-6917.

| Important Questions                                       | Answers                                                                                                                   | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | <b>\$0 Individual / \$0 Family</b>                                                                                        | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your contract or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .                                                                                |
| Are there other <u>deductibles</u> for specific services? | No                                                                                                                        | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                                                   |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | <b>\$1,500 Individual / \$3,000 Family</b>                                                                                | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?  | Premiums, balance-billed charges, Health care this plan doesn't cover, Penalties                                          | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                           |
| 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 <i>specific</i> covered services, such as office visits.                                                                                                                                                                                                                                                                                                               |
| Does this plan use a <u>network of providers</u> ?        | Yes. See <a href="http://www.humana.com">www.humana.com</a> or call 1-800-833-6917 for a list of Network <u>providers</u> | If you use a network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ?         | Yes. You need a referral to see a specialist.                                                                             | This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .                                                                                                                                                                                                                                                                          |
| 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 contract or plan document for additional information about <u>excluded services</u> .                                                                                                                                                                                                                                                                                      |

**Questions:** Call 1-800-833-6917 or visit us at [www.humana.com](http://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](http://www.dol.gov/ebsa/healthreform) or call 1-800-833-6917 to request a copy



- **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 <b>provider's</b> 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:<br>20% coinsurance                   | Not Covered                                  |                                                                                                                                               |
|                                                               | 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                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less.<br>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                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.humana.com">www.humana.com</a> . | Level 1 – Preferred/ low-cost generics         | \$4 copay (Retail)<br>\$8 copay (Mail Order)   | Not Covered                                  | Preauthorization may be required, penalty will be 50%.<br>30 day supply (Retail)<br>90 day supply (Mail Order)                              |
|                                                                                                                                                                                                         | Level 2 – Nonpreferred generic                 | \$10 copay (Retail)<br>\$20 copay (Mail Order) | Not Covered                                  | See Level 1 for Limitations and Exceptions                                                                                                  |
|                                                                                                                                                                                                         | Level 3 – Preferred brands                     | \$20 copay (Retail)<br>\$40 copay (Mail Order) | Not Covered                                  | See Level 1 for Limitations and Exceptions                                                                                                  |
|                                                                                                                                                                                                         | Level 4 – Nonpreferred brands                  | 35% coinsurance                                | Not Covered                                  | See Level 1 for Limitations and Exceptions                                                                                                  |
|                                                                                                                                                                                                         | Level 5 –Specialty drugs                       | 35% coinsurance                                | Not Covered                                  | Preauthorization required, penalty will be 50% .<br>25% coinsurance when filled via a preferred network specialty pharmacy                  |
| <b>If you have outpatient surgery</b>                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance                                | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less<br>Cost share may vary based on where service is performed |
|                                                                                                                                                                                                         | Physician/surgeon fees                         | 20% coinsurance                                | Not Covered                                  | Cost share may vary based on where service is performed                                                                                     |
| <b>If you need immediate medical attention</b>                                                                                                                                                          | 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.                                                                                    |
| <b>If you have a hospital stay</b>                                                                                                                                                                      | Facility fee (e.g., hospital room)             | 20% coinsurance                                | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less                                                            |
|                                                                                                                                                                                                         | 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                                                                              |
|-------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | 20% coinsurance                          | Not Covered                                  | _____none_____                                                                                        |
|                                                                               | Mental/Behavioral health inpatient services  | 20% coinsurance                          | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less.                     |
|                                                                               | Substance use disorder outpatient services   | 20% coinsurance                          | Not Covered                                  | _____none_____                                                                                        |
|                                                                               | Substance use disorder inpatient services    | 20% coinsurance                          | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less.                     |
| <b>If you are pregnant</b>                                                    | 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                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less.                     |
| <b>If you need help recovering or have other special health needs</b>         | Home health care                             | 20% coinsurance                          | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less.                     |
|                                                                               | Rehabilitation services                      | 20% coinsurance                          | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less.                     |
|                                                                               | Habilitation services                        | 20% coinsurance                          | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less.                     |
|                                                                               | Skilled nursing care                         | 20% coinsurance                          | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less<br>30 days per year. |

| 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                                                          |
|----------------------------------------|---------------------------|------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------|
|                                        | Durable medical equipment | 20% coinsurance                          | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less. |
|                                        | Hospice service           | 20% coinsurance                          | Not Covered                                  | Preauthorization may be required, penalty will be 50% or \$500 whichever is less. |
| 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 contract or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery for morbid obesity
- 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 contract or plan document for other covered services and your costs for these services.)

- Chiropractic care – spinal manipulations are covered
- Hearing aids
- Private-duty nursing while hospital confined or in a home health setting
- 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, PO Box 149104, Austin, TX 78714-9104, Phone: 512-463-6169 or 800-578-4677.

## 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, PO Box 149104, Austin, TX 78714-9104, Phone: 512-463-6169 or 800-578-4677

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 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 contract 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.**

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page*

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## 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 \$6,210.00
- Patient pays \$ 1,330.00

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                   |
|----------------------|-------------------|
| Deductibles          | \$0.00            |
| Copays               | \$30.00           |
| Coinsurance          | \$1,300.00        |
| Limits or exclusions | \$0.00            |
| <b>Total</b>         | <b>\$1,330.00</b> |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,680.00
- Patient pays \$720.00

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                 |
|----------------------|-----------------|
| Deductibles          | \$0.00          |
| Copays               | \$700.00        |
| Coinsurance          | \$0.00          |
| Limits or exclusions | \$20.00         |
| <b>Total</b>         | <b>\$720.00</b> |

## 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.

**Questions:** Call 1-800-833-6917 or visit us at [www.humana.com](http://www.humana.com).

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