Illinois

# Humana Platinum 1000/Chicago HMOx

## About this plan

Humana Platinum 1000/Chicago HMOx is a Health Maintenance Organization (HMO) health plan. You must choose a primary care physician (PCP) from our network of local 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 **Chicago 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 the mail order pharmacy, RightSource®. Visit **RightSourceRx.com**.

- To find a pharmacy in your area, visit **Humana.com**. Once there, Humana's easy-to-use Rx Tool will help you find an in-network pharmacy in your area.

**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)

This plan is available in the following counties: Cook, Lake, McHenry

Humana®

Health Insurance Marketplace

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**Date the plan starts –** The initial Open Enrollment period for 2015 coverage is November 15, 2014 to February 15, 2015. Coverage can start as early as January 1, 2015. 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 policy. 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 **RightSourceRx.com**, there is no coverage, except in an emergency as defined in your policy.

## 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 policy for a full list of benefits covered.

The medical insurance policy 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 policy will apply.

# Humana Platinum 1000/Chicago HMOx

| | | 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 | $1,000 | $2,000 |
| **Prescription drug deductible*** | Amount you'll pay out of pocket before the plan pays for prescription drugs<br>› Prescription drug out-of-pocket costs, including prescription drug deductible, apply to the out-of-pocket maximum<br>› Level 1 & level 2 drugs are subject to copay, not deductible | $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<br>› Once you reach your out-of-pocket maximum, the plan pays 100% of all covered expenses<br>› Copays do not accumulate toward the deductible but they do accumulate to the out-of-pocket maximum<br>› 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.

| | | |
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| **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<br>› A PCP referral is not required for in-network OB/GYN services | This plan pays 100% |
| **Diagnostic office visits and urgent care centers** | › Includes maternity and mental health services<br>› Your PCP will refer you to a specialist or urgent care center when necessary<br>• Specialists and urgent care centers must be in-network | This plan pays 100% after you pay a copay per visit:<br>• $25 for a PCP<br>• $35 for a specialist<br>• $50 for an urgent care visit |
| **Diagnostic lab and X-rays** | › Includes allergy testing<br>› Includes maternity and mental health services | The plan pays 100% of the first $500 per covered plan member per calendar year; then you pay 20% after you pay your deductible<br><br>For advanced imaging, pulmonary function studies, cardiac catheterization, EKG, ECG and EEG, you pay 20% after you pay your deductible |

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| | | In-network |
|---|---|---|
| **Emergency room** | Emergencies are life-threatening illnesses or injuries<br>› 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 | You pay 20% after you pay your deductible |
| **Ambulance** | | You pay 20% after you pay your deductible |
| **Hospital stay** | Inpatient<br>› Facility fee (e.g. hospital room)<br>› Physician/surgeon fees<br>Outpatient<br>› Facility fee (e.g. ambulatory surgery center)<br>› 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** | Mental illness and chemical/alcohol dependency<br>› Includes inpatient and outpatient services | You pay 20% after you pay your deductible |
| **Other medical services** | Including, but not limited to:<br>› Skilled nursing facility – visit limits do not apply<br>› Physical, occupational, cognitive, speech, audiology, and respiratory therapy – visit limits do not apply<br>› Spinal manipulations, adjustments, and modalities – up to 40 visits per calendar year<br>› Cardiac therapy – up to 72 visits per calendar year<br>› Home healthcare services – visit limits do not apply<br>› Hospice care – visit limits do not apply | You pay 20% after you pay your deductible |
| **Prescription drugs** | The pharmacy network name is **"Select Rx Network"**<br>› 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<br>› In-network retail pharmacies are CVS, Walmart and Sam's Club pharmacies<br>• You pay a copay for each covered prescription fill or refill up to a 30-day supply at these in-network pharmacies<br>• You do not need to be a member of Sam's Club to have your prescription filled at Sam's Club pharmacies<br>› This plan also gives you access to the mail order pharmacy, RightSource<br>• Visit **RightSourceRx.com**<br>• Mail order through **RightSourceRx.com** covers up to a 90 day supply at 2 times the retail copay<br>› Find out what drugs are included at **Humana.com** with the Rx Tool<br>• The prescription drug plan name is **Rx5 Plus** | **Level 1**<br>• $5 copay for covered preferred generic drugs<br>**Level 2**<br>• $10 copay for covered non-preferred generic drugs<br>**Level 3**<br>• $20 copay for covered preferred brand name drugs†<br>**Level 4**<br>• 35% coinsurance for covered non-preferred brand name drugs†<br>**Level 5**<br>• 35% coinsurance for covered specialty drugs*†<br>* Some specialty drugs are 25% when purchased from a preferred network specialty drug pharmacy like **RightSourceRx.com**<br>† After deductible |

| | | In-network |
|---|---|---|
| **Children's vision care** | Children, up to age 19, are covered under this plan<br>› Exam with dilation as necessary (limit 1 per year)<br>› Medically necessary eyeglass lenses with covered frames or contact lenses (limit 1 per year)<br>• Eyeglass lens options – standard polycarbonate and/or standard scratch coating<br>› Low vision<br>• Supplemental testing (limit 1 every 2 years)<br>› Vision aids (limit 1 every 3 years)<br>• Video magnification aids (1 every 5 years)<br>› 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<br>› The above services are not all inclusive; see the plan policy for more details | You pay 50% after you pay your deductible |

## 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 policy 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.
- There are primary care physician (PCP) selection requirements and specialist referral requirements.
- Primary care physician (PCP) referral is not required for network obstetrician, dermatologist, and gynecologist services.

**When you go to an out-of-network provider:**
- There is no coverage for out-of-network providers, except for emergency care as defined in your policy.

## 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 policy for a complete list of limitations and exclusions. Certain services and prescription drugs require preauthorization and notification before services are rendered. Please visit **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 maximum allowable fee or reimbursement limit
- 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 rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary
- Services not medically necessary, except for routine preventive services as stated in the policy
- Services that require referral from a primary care physician (PCP) if the referral was not obtained
- Services provided by a non-network provider, except when medically necessary to provide emergency care as stated in the policy

**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

**Immunizations**
- Immunizations except as stated in the policy

**Dental, foot care, hearing, and vision services**
- Dental services (except for dental injury), appliances, or supplies
- Foot care services other than for diabetes
- Hearing care that is routine except as stated in the policy
- Vision examinations or testing, eyeglasses, or contact lenses except as stated in the policy

**Pregnancy and sexuality services**
- Elective medical or surgical abortion except as stated in the policy
- Elective caesarean section delivery unless medically necessary
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- Reversal of sterilization
- Infertility services except as stated in the policy
- Sex change services and sexual dysfunction unless ordered by a healthcare practitioner
- Services rendered in a premenstrual syndrome clinic

**Obesity-related services**
- Any treatment for obesity except as stated in the policy
- Surgical procedures for the removal of excess skin and/or fat due to weight loss

**Illness/injury circumstances**
- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated in the policy
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, influence of an illegal substance, being intoxicated, or engaging in an illegal occupation

**Care in certain settings**
- Private duty nursing except as stated in the policy
- 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**
- 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 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 are extended 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 unless medically necessary
- Contraceptives when prescribed for purposes other than to prevent pregnancy
- Cranial banding
- 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 as stated in the policy
- Hyperhidrosis surgery
- Immunotherapy for food allergy
- Light treatment for Seasonal Affective Disorder (S.A.D.)
- Living expenses, travel, transportation, except as stated in the policy
- 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 of nicotine habit or addiction except FDA approved smoking cessation drugs or supplies with a prescription from a healthcare practitioner
- Any drug, medicine or device which is not FDA approved
- Medications, drugs or hormones to stimulate growth unless medically necessary
- Legend drugs not recommended or deemed necessary by a healthcare practitioner 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; experimental or investigational use drugs
- Over the counter drugs (except insulin, drugs on the Women's Healthcare Drug List with a prescription, or drugs with a prescription prescribed for use for a covered preventive service) or drugs available in prescription strength without a prescription
- Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order
- Vitamins, dietary products, and any other non-prescription supplements
- Over the counter medical items or supplies that are available without a prescription except for preventive services
- Prescription drugs filled at a non-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
- Oversized 61 and above lens or lenses; artistically painted lenses; premium lenes 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 provided by a non-network provider

**Pediatric Dental (Available with Off Exchange Plans Only)**

- 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)
- 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-medications
- Orthodontic services or repair and replacement of orthodontic appliances
- 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 expressly stated in the policy
- Services not eligible for benefits based on a clinical review, does not offer a favorable prognosis, or does not have uniform professional acceptance
- Services provided by a non-network provider

# Add Humana Dental Smart Choice to protect a healthy smile

## The following dental policy 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, up to the age of 19 years, can be covered under an individual or family policy 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.**

# Notes

# Notes

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