


## HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE

COR: WI SG NPOS 14

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 11/01/2016

Coverage For: Individual + Family | Plan Type: NPOS

 <b>This is only a summary.</b> If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <a href="http://www.humana.com">www.humana.com</a> or by calling <a href="http://www.humana.com">www.humana.com</a> or by calling 1-866-4ASSIST (427-7478).		
Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network: <b>\$2,000 Individual / \$4,000 Family</b> Non-Network: <b>\$6,000 Individual / \$12,000 Family</b> Doesn't apply to prescription drugs and network preventive services. Co-insurance and co-payments don't count toward the deductible	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 policy 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?	Yes. Prescription drug coverage Network: <b>\$250 Individual / \$500 Family</b> Non-Network: <b>\$750 Individual / \$1,500 Family</b> There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses	Yes. For Network providers <b>\$6,350 Individual / \$12,700 Family</b> For Non-Network providers <b>\$19,050 Individual / \$38,100 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, Non-network transplant, non-network prescription drugs, non-network specialty drugs	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.

**Questions:** Call [www.humana.com](http://www.humana.com) or by calling 1-866-4ASSIST (427-7478) 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 [www.humana.com](http://www.humana.com) or by calling 1-866-4ASSIST (427-7478) to request a copy.

Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.humana.com">www.humana.com</a> or call 1-866-4ASSIST (427-7478) for a list of Network providers. For Prescription Drugs: National Rx Network	If you use an in-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 in-network doctor or hospital may use an out-of-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> ?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .



- **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 network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$40 copay/visit	30% coinsurance	-----none-----
	Specialist visit	\$70 copay/visit	30% coinsurance	-----none-----
	Other practitioner office visit	Chiropractor Exam: \$70 copay/visit	Chiropractor Exam: 30% coinsurance	-----none-----
	Preventive care / screening / immunization	No charge	30% coinsurance	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b></p> <p><b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.humana.com">www.humana.com</a>.</b></p> <p><b><u><a href="#">Click here</a></u></b></p>	Level 1 - Lowest cost generic and brand-name drugs	\$10 copay (Retail) \$25 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	<p>30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order) Non-network cost sharing does not count toward the out-of-pocket limit.</p>
	Level 2 - Higher cost generic and brand-name drugs	\$40 copay (Retail) \$100 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	\$70 copay (Retail) \$175 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Specialty drugs	35% coinsurance	50% coinsurance	25% coinsurance when filled via a preferred network specialty pharmacy Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	40% coinsurance	50% coinsurance	-----none-----
If you need immediate medical attention	Emergency room services	\$500 copay/visit	\$500 copay/visit	Copayment waived if admitted
	Emergency medical transportation	40% coinsurance	40% coinsurance	-----none-----
	Urgent care	\$100 copay/visit	30% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fee	40% coinsurance	50% coinsurance	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40 copay/visit	30% coinsurance	-----none-----
	Mental/Behavioral health inpatient services	40% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Substance use disorder outpatient services	\$40 copay/visit	30% coinsurance	-----none-----
	Substance use disorder inpatient services	40% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If you are pregnant	Prenatal and postnatal care	40% coinsurance	50% coinsurance	-----none-----
	Delivery and all inpatient services	40% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	100 visit limit per calendar year Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	\$70 copay/visit	30% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50% Physical, Occupational, Speech, Audiology, and Cognitive Therapy:

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				40 visits per calendar year combined limit for Physical Therapy/ Occupational Therapy/ Speech Therapy/ Cognitive Therapy/ Audiology Therapy For non-network, 40 visits per calendar year combined limit for Physical Therapy/ Occupational Therapy/ Speech Therapy/ Cognitive Therapy/ Audiology Therapy
	Habilitation services	\$70 copay/visit	30% coinsurance	
	Skilled nursing care	40% coinsurance	50% coinsurance	60 days per confinement Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	40% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50% for durable medical equipment \$750 and over Excludes vehicle and home modifications, exercise and bathroom equipment
	Hospice service	40% coinsurance	50% coinsurance	-----none-----
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	-----none-----
	Glasses	Not Covered	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 policy or plan document for other excluded services.)		
<ul style="list-style-type: none"> <li>Acupuncture, unless it is prescribed by a physician for rehabilitation purposes</li> <li>Bariatric surgery</li> <li>Child dental check-up</li> <li>Child eye exam</li> <li>Child glasses</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic surgery, unless to correct a functional impairment</li> <li>Dental care (Adult), unless for dental injury of a sound natural tooth</li> <li>Hearing aids, unless under age 18</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside of the U.S</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care - spinal manipulations are covered

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.hhs.gov](http://www.hhs.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:

Humana, Inc.: [www.humana.com](http://www.humana.com) or 1-866-4ASSIST (427-7478)

Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Wisconsin Office of the Commissioner of Insurance, PO Box 7873, Madison, WI 53707-7873, Phone: 608-266-3585 or 608-266-0103 or 800-236-8517, TDD: Dial 711 and ask for 608-266-3586, Email: [ociquestions@wisconsin.gov](mailto:ociquestions@wisconsin.gov), Website: <http://oci.wi.gov/index.htm>

**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.**

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



## HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE

COR: WI SG NPOS 14

Coverage Examples

Coverage Period: Beginning on or after 11/01/2016

Coverage For: Individual + Family | Plan Type: NPOS

### 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: \$3,700
- Patient pays: \$3,840

##### 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	\$2,000
Copays	\$40
Coinsurance	\$1,800
Limits or exclusions	\$0
<b>Total</b>	<b>\$3,840</b>

#### Managing type 2 diabetes

(routine maintenance of  
a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$3,480
- Patient pays: \$1,920

##### 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	\$200
Copays	\$1,700
Coinsurance	\$0
Limits or exclusions	\$20
<b>Total</b>	<b>\$1,920</b>

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### 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.

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- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-866-427-7478 or send an email to [accessibility@humana.com](mailto:accessibility@humana.com), or if you use a TTY, call 711.

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Discrimination Grievances  
P.O. Box 14618  
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-866-427-7478 or if you use a TTY, call 711.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

**U.S. Department of Health and Human Services**

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

### Multi-Language Interpreter Services

**English:** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-866-427-7478 (TTY: 711).

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-427-7478 (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 1-866-427-7478 (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 1-866-427-7478 (TTY: 711).

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**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-427-7478 (TTY: 711).

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-427-7478 (телетайп: 711).

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-427-7478 (TTY: 711).

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-427-7478 (ATS : 711).

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-427-7478 (TTY: 711).

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-427-7478 (TTY: 711).

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-427-7478 (TTY: 711).

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-427-7478 (TTY: 711).

**日本語 (Japanese):**  
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-427-7478 (TTY: 711) まで、お電話にてご連絡ください。

**فارسی (Farsi):**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-427-7478 (TTY: 711) تماس بگیرید.

**Diné Bizaad (Navajo):** Díí baa akó nínízin: Díí saad bee yánílt'ígo Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kóji' hódílnih 1-866-427-7478 (TTY: 711).

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-427-7478 (رقم هاتف الصم والبكم: 711).