Commonwealth Optimum PPO: Kentucky Employees' Health Plan

Coverage Period: 01/01/2013-12/31/2013

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

Coverage for: Single/Couple/Parent Plus/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 kehp.ky.gov or by calling **1-887-KYSPIRIT (877-597-7474).**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network (Par) $370 single/$740 family; Out-of-Network (non-Par) $740 single/$1,480 family. Preventive care, **Copayments,** and prescriptions do not apply to 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network (Par) $1,390 single/$2,780 family; Out-of-Network (non-Par) $2,780 single/ $5,550 family.	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?	Copays, prescriptions, premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count towards 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 1-877-KYSPIRIT (1-877-597-7474).	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**.
Do I need a referral to see a specialist?	No.	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 the **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $20 or $25) 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 **PAR provider**s 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	$16 copay	30% coinsurance	————————none————————
	Specialist visit	$21 copay	30% coinsurance	————————none————————
	Other practitioner office visit	$16 copay	30% coinsurance	Chiropractic exams
	Preventive care/screening/immunization	$11 copay	30% coinsurance	-Routine well adult exam limited to one per year. -In-Network (Par) labs, x-rays, and mammograms are not subject to a copayment.
If you have a test	Diagnostic test (x-ray, blood work) Clinic Outpatient	 No Charge. $16 copayment	 30% coinsurance 30% coinsurance	Your cost if In-network (Par) diagnostic labs/x-rays is performed in a clinic without seeing the physician, an office visit copay would apply.
	Imaging (CT/PET scans, MRIs) Clinic Outpatient	 No charge $16 copayment	 30% coinsurance 30% coinsurance	-Your cost if In-Network (Par) advanced imaging is performed in a clinic without seeing the physician, an office visit copay would apply. -Pre-auth required and you or your provider will be subject to a penalty if not received.

If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at kehp.ky.gov or 1-877-KYSPIRIT (1-877-597-7474).	Generic drugs	$11 copay 30 day supply	30% coinsurance	90 day supply for maintenance drugs at participating pharmacies and mail order.
	Formulary drugs	$26 copay 30 day supply	30% coinsurance	90 day supply for maintenance drugs at participating pharmacies and mail order.
	Non-formulary drugs	$48 copay 30 day supply	30% coinsurance	90 day supply for maintenance drugs at participating pharmacies and mail order.
	Specialty drugs	Same as Non Specialty Drugs		Same as Non Specialty Prescriptions.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	Pre-auth may be required and you or your provider will be subject to a penalty if not received.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services: True Emergency ER Services True ER – All other services Non-Emergency ER Services	$92 copay 15% coinsurance Not Covered	$92 copay 30% coinsurance Not Covered	-In-network (Par) True ER is not subject to the deductible. -No coverage for non-emergency ER services.
	Emergency medical transportation	15% coinsurance	15% coinsurance	
	Urgent care	$21 copay	30% coinsurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance	Pre-auth required and you your provider will be subject to a penalty if not received.
	Physician/surgeon fee	15% coinsurance	30% coinsurance	————————none————————

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Therapy Services Exam Labs & X-rays: Clinic Outpatient	 $21 copay $16 or $21 copayment No charge $16 copayment	 30% coinsurance 30% coinsurance 30%coinsurance 30% coinsurance	Pre-auth required and you or your provider will be subject to a penalty if not received.
	Mental/Behavioral health inpatient services	15% coinsurance	30% coinsurance	Pre-auth required and you or your provider will be subject to a penalty if not received.
	Substance use disorder outpatient services: Therapy Services Exam Labs & X-rays: Clinic Outpatient	 $21 copay $16 or $21 copayment No charge $16 copayment	 30% coinsurance 30% coinsurance 30%coinsurance 30% coinsurance	Pre-auth required and you or your provider will be subject to a penalty if not received.
	Substance use disorder inpatient services	15% coinsurance	30% coinsurance	Pre-auth required and you or your provider will be subject to a penalty if not received.
If you are pregnant	Prenatal and postnatal care	$21 copay	30% coinsurance	————————none————————
	Delivery and all inpatient services	15% coinsurance	30% coinsurance	————————none————————
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	Limited to 60 visits. Pre-auth required and you or your provider will be subject to a penalty if not received.
	Rehabilitation services	15% coinsurance	30% coinsurance	Physical, occupational, and speech therapy is limited to 30 visits each.
	Habilitation services	15% coinsurance	30% coinsurance	
	Skilled nursing care	15% coinsurance	30% coinsurance	Limited to 30 visits
	Durable medical equipment	15% coinsurance	30% coinsurance	Pre-auth may be required and you or your provider will be subject to a penalty if not received.
	Hospice service	No charge	No charge	————————none————————
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for eye exams.
	Glasses	Not covered	Not covered	No coverage for glasses.
	Dental check-up	Not covered	Not covered	No coverage for dental check-ups.

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
- Dental care (Adult and child)
- Infertility services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult and child)
- Routine foot 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.)

- Bariatric surgery (Requires pre-auth)
- Chiropractic care(Limited to 26 visits and no more than 1 visit per day)
- Cosmetic surgery (Requires prior auth. Services will only be considered if due to a bodily injury or illness and functional impairment is present.)
- Hearing aids (Limited to $1,400 per ear every 3 years through the age of 17)

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 1-877-KYSPIRIT (1-877-597-7474). 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.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: 1-877-KYSPIRIT (1-877-597-7474).

Humana Grievance and Appeals
P.O. Box 14546
Lexington, KY 40512-4546

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** $6,000
- **Patient pays** $1,540

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	$370
Copays	$230
Coinsurance	$790
Limits or exclusions	$150
Total	**$1,540**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,060
- **Patient pays** $1,340

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	$370
Copays	$730
Coinsurance	$160
Limits or exclusions	$80
Total	**$1,340**

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, review 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.