Florida

Humana Silver 4250/National POS – OpenAccess + Children's Dental

About this plan

Humana Silver 4250/National POS – OpenAccess + Children's Dental is a Point of Service (POS) health plan. You have a large network of healthcare providers to choose any primary care physician (PCP) to help you maintain your health and well-being. You have the freedom to visit any doctor, specialist or hospital. However, your out-of-pocket costs are lower when you choose an in-network provider.

› This plan covers inpatient and outpatient medical services, and includes prescription drug coverage. It also provides all preventive services and includes all essential health benefits like maternity and childbirth and children's dental care.

Selecting your healthcare providers – When you enroll in this plan, you can receive care from any doctor, specialist or hospital you choose, but you will save more money by choosing a provider within a select group of healthcare providers in the network. You should choose a PCP from this group with whom you can build a trusting relationship as they are your first point of contact to maintain your health and well-being. You can receive healthcare services from any PCP in this group, and you can use any specialist or hospital of your choice within the network without a referral from your PCP.

› 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 **National POS – OpenAccess**

The pharmacy network – The pharmacy network name is **"National Rx 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: Alachua, Baker, Bradford, Brevard, Broward, Charlotte, Clay, Citrus, Collier, Columbia, Dixie, Duval, Flagler, Gilchrist, Hernando, Hillsborough, Indian River, Lake, Lee, Levy, Manatee, Marion, Martin, Miami-Dade, Nassau, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Saint Johns, Saint Lucie, Sarasota, Seminole, Union, Volusia

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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 – This plan gives you the freedom to receive care from any doctor, specialist or hospital you choose, but you will save more money by using in-network healthcare providers. In addition, you will save more money by having your prescriptions filled at in-network pharmacies. This includes the mail order service, **RightSourceRx.com.**

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.

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		In-network		Out-of-network	
		Individual	Family	Individual	Family
Combined medical, children's vision care and children's dental care deductible*	The amount of covered expenses you'll pay out of your pocket before the plan pays for covered services	$4,250	$8,500	$8,500	$17,000
Prescription drug deductible*	Amount you'll pay out of pocket before the plan pays for prescription drugs › Prescription drug out-of-pocket costs, including prescription drug deductible, apply to the out-of-pocket maximum › Level 1 drugs are subject to copay, not deductible	$1,500	$3,000	$4,500	$9,000
Annual out-of-pocket maximum*	The most you pay toward the covered cost of your healthcare for the calendar year; includes copays, deductibles, coinsurance and pharmacy charges; does not include the premium › Once you reach your out-of-pocket maximum, the plan pays 100% of all covered expenses › Copays do not accumulate toward the deductible but they do accumulate to the out-of-pocket maximum › Deductible and out-of-pocket maximum start over each new calendar year	$6,250	$12,500	$25,000	$50,000
Coinsurance*	The percentage you pay for covered medical services	You pay 20% of covered expenses after you pay your deductible		You pay 40% 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.

Lifetime maximum	The total amount this plan will pay for covered expenses in your lifetime	Unlimited	
Preventive care	Child Preventive Services (includes well office visit, lab and child immunizations, flu and pneumonia immunizations) birth to age 17	This plan pays 100%	You pay 40%
	Includes preventive office visits, lab tests, X-rays, child immunizations (age 17-18), flu and pneumonia immunizations, Pap tests, mammograms, prostate screening, certain endoscopic services and more	This plan pays 100%	You pay 40% after you pay your deductible

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		In-network	Out-of-network
Diagnostic office visits and urgent care centers	Includes maternity and mental health services › Concentra, a national healthcare company and subsidiary of Humana Inc., is an in-network urgent care facility for this plan. To find a Concentra location near you, visit **Concentra.com**	This plan pays 100% after you pay a copay per visit: • $35 for a PCP • $60 for a specialist If Concentra in-network, insert: • $60 for an urgent care visit at a Concentra location • $100 for an urgent care visit at a non-Concentra location	You pay 40% after you pay your deductible
Diagnostic lab and X-rays	› Includes allergy testing › 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 For advanced imaging, pulmonary function studies, cardiac catheterization, EKG, ECG and EEG, you pay 20% after you pay your deductible	You pay 40% after you pay your deductible
Emergency room	Emergencies are life-threatening illnesses or injuries › 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	

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		In-network	Out-of-network
Hospital stay	Inpatient › Facility fee (e.g. hospital room) › Physician/surgeon fees Outpatient › Facility fee (e.g. ambulatory surgery center) › Physician/surgeon fees	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
Maternity	Delivery and related inpatient and outpatient services	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
Transplants		You pay 20% when services are received from a Humana National Transplant Network provider after you pay your deductible	You pay 40% after you pay your deductible; this plan pays up to $35,000 per transplant
Mental health	Mental illness and chemical/alcohol dependency › Includes inpatient and outpatient services	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
Other medical services	Including, but not limited to: › Skilled nursing facility – up to 60 days per calendar year › Physical, occupational, speech, cardiac, and respiratory therapy – combined, up to 35 visits per calendar year › Cognitive and audiology therapy – visit limits do not apply › Spinal manipulations, adjustments, and modalities – up to 26 visits per calendar year › Home healthcare services – up to 60 visits per calendar year › Hospice Care	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible

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		In-network	Out-of-network
Prescription drugs	The pharmacy network name is **"National Rx Network"** › This plan also gives you access to the mail order pharmacy, RightSource • Visit **RightSourceRx.com** • Mail order through **RightSourceRx.com** covers up to a 90 day supply at 2 times the retail copay › If you use an out-of-network pharmacy, you'll need to pay the full cost up front and then ask Humana to pay you back by submitting a claim › Find out what drugs are included at **Humana.com** with the Rx Tool • The prescription drug plan name is **Rx4 EHB**	**Level 1** • $15 copay for covered low cost generic and brand name drugs **Level 2** • $35 copay for covered higher cost generic and brand name drugs† **Level 3** • $50 copay for covered high cost, mostly brand name drugs† **Level 4** • 50% coinsurance for covered high-technology drugs – certain brand name drugs and self-administered injectable medications*† * Covered specialty drugs are 40% when purchased from a preferred network specialty drug pharmacy like **RightSourceRx.com** † After deductible	You pay 30% after you pay your copay and deductible; however, after the plan has paid its required portion, you are responsible for 100% of any additional charges

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		In-network	Out-of-network
Children's vision care	Children, up to age 19, are covered under this plan › Exam with dilation as necessary (limit 1 per year) › Medically necessary eyeglass lenses with covered frames or contact lenses (limit 1 per year) • Eyeglass lens options – standard polycarbonate and/or standard scratch coating › Low vision • Supplemental testing (limit 1 every 2 years) › Vision aids (limit 1 every 3 years) • Video magnification aids (1 every 5 years) › 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 › The above services are not all inclusive; see the plan's medical insurance policy for more details	You pay 50% after you pay your deductible	You pay 50% after you pay your deductible
Children's dental care	Children, up to age 19, are covered under this plan › Diagnostic and preventive services • Routine oral exams, periodontal exams, cleanings (limit 2 each per year) • Bitewing X-rays (limit 2 sets per year, excludes full mouth and panoramic) • Topical fluoride treatment (limit 2 per year) • Sealant › Minor restorative services and surgical • Prefabricated crowns (limit 1 per 5 years, primary teeth only) • Fillings • Simple oral surgery – Extractions › Major restorative services • Resin onlays, inlays and crowns (limit 1 per tooth per 5 years, permanent teeth only) • Root extraction › More than 225,000 dentist locations in the Humana Dental PPO network. Visit **Humana.com/findadoctor** to find dentists in your area › See the medical schedule of benefits for complex oral surgery and medically necessary orthodontia benefit details	You pay 50% after you pay your deductible	You pay 50% after you pay your deductible

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.

When you go to an out-of-network provider:
- The amount you pay for health benefits is based on Humana's maximum allowable fee. The amount you pay for dental and vision benefits is based on Humana's reimbursement limit.
- The provider can balance bill you for charges greater than the maximum allowable fee and/or the reimbursement limit.

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

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
- 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
- Sex change services and sexual dysfunction
- 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, or engaging in an illegal occupation

Care in certain settings
- Private duty nursing
- 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
- Contraceptives when prescribed for purposes other than to prevent pregnancy
- Cranial banding, unless otherwise determined by us
- 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 for CMJ, or any jaw joint problem except as stated in the policy
- 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
- 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

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 lens 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

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

Offered by Humana Medical Plan, Inc. Applications are subject to eligibility requirements. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage call or write your Humana insurance agent or broker.

Florida Compare Care resources from the Agency of Health Care Administration (AHCA) can be found at http://www.floridahealthfinder.gov/. The site includes helpful information about Florida healthcare, plans and facilities.

Add extra benefits for protection

The following dental policies are available to you at an extra cost

Make your Humana plan fit your needs even better. Extra benefits are an easy and affordable way to get the coverage you need.

Dental

Protect your healthy smile with affordable, easy-to-use optional dental benefits from one of the nation's largest dental insurers. For a low monthly premium, you can use a provider located in more than 225,000 dentist locations. Just choose the type of coverage that meets your needs:

Loyalty Plus rewards members for loyalty by increasing benefits from years one to three, with increasing coverage on services like routine exams, root canals and crowns, a one-time deductible for as long as you are on the plan, and no copayments or waiting periods. You can go to the dentist you prefer with the comfort of knowing this plan pays the same percentage of the cost no matter which dentist you visit.

Traditional Plus includes coverage for preventive, basic, and major services. You can go to network or non-network dentists, but you'll pay less when you choose dentists in the network.

Preventive Plus covers the most common preventive and basic services. Discounts are available for major services and basic services the plan doesn't cover.

Dental Savings Plan Plus is not insurance, but a discount plan that could save you 15–40% on many services, including dental, vision, Rx, hearing or alternative medicine.

Preventive Plus Package for Veterans is exclusively for U.S. Veterans. It provides dental coverage at 100 percent for many in-network dental preventive procedures, low deductibles, no copayments, and offers many extras such as discount on vision, hearing, prescriptions, and clinic care services.

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.

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