

**MISSOURI/KANSAS  
Option 2**

Plan pays for services provided or arranged by your **PARTICIPATING** primary care physician

**Benefits per covered person:**

<b>Preventive Care</b>	<ul style="list-style-type: none"> <li>• Routine immunizations (<i>except for travel</i>)</li> <li>• Routine physical exams</li> <li>• Well-child care</li> <li>• Well-woman care (<i>may self-refer to OB/GYN</i>)</li> <li>• Well-men care (<i>Prostate exam</i>) (1)</li> </ul>	<b>100%</b>
<b>Physician Services</b> <i>(Most visits to specialists must be authorized by a primary care physician)</i>	<ul style="list-style-type: none"> <li>• Prenatal care (<i>office visit copayment applies to first visit only</i>)</li> <li>• Physician office visits (<i>office visits in conjunction with an illness or injury</i>)</li> <li>• Allergy test</li> <li>• Allergy serums and injections</li> <li>• Emergency room physician</li> </ul>	<p><b>100%</b> after \$25 copayment per visit to primary care physician or \$50 copayment per visit to specialist</p> <p><b>100%</b> after \$10 copayment per visit</p> <p><b>100%</b></p>
<b>Hospital Services</b>	<ul style="list-style-type: none"> <li>• Inpatient care (<i>semiprivate room, ancillary services, physician visits</i>) (<i>prior authorization required</i>)</li> <li>• Preadmission testing</li> <li>• Outpatient surgical care (<i>includes ambulatory surgical center</i>)</li> <li>• Outpatient non surgical care</li> <li>• Emergency care (<i>emergency room, emergency services</i>)</li> </ul>	<p><b>100%</b> after \$500 copayment per day for first five days, (<i>maximum of \$2,500</i>)</p> <p><b>100%</b></p> <p><b>100%</b> after \$250 copayment</p> <p><b>100%</b> after \$250 copayment (<i>waived if admitted</i>)</p>
<b>Prescription Drugs Rx4 Drug List</b>	<p><b>Options Rx4 Network</b> Level One: \$10 Level Two: \$30 Level Three: \$50 Level Four: 25%** of the total required payment to the dispensing pharmacy per prescription or refill. Please check on <b>Humana.com</b> for complete listing. (<i>Maximum Level 4 out-of-pocket limited to \$2,500 per member per plan year</i>)</p> <p><b>Out of Network:</b> No benefit</p>	
<b>RightSource Mail Order</b> ( <i>Mail order drug program 90 day supply</i> )		<p>Level 1: \$20 copayment Level 2: \$60 copayment Level 3: \$100 copayment</p>
<b>Other Medical Services</b>	<ul style="list-style-type: none"> <li>• Skilled nursing facility (<i>up to 30 days per calendar year</i>)</li> <li>• Home health care (<i>up to 60 visits per calendar year</i>)</li> <li>• Ambulance (<i>up to \$500 per occurrence</i>)</li> <li>• Durable medical equipment</li> <li>• Respiratory</li> <li>• Radiation</li> <li>• Lab</li> <li>• Hospice services</li> <li>• Physical or speech therapy (<i>limited to 60 visits combined per calendar year</i>)</li> <li>• Advanced Imaging (PET, MRI, CT, etc.)</li> <li>• Diabetes services                             <ul style="list-style-type: none"> <li>– Diabetes education</li> <li>– Diabetes equipment</li> <li>– Diabetes supplies (<i>30-day supply per copayment</i>)</li> </ul> </li> <li>• Chiropractic examinations (<i>up to 26 visits per year</i>)                             <ul style="list-style-type: none"> <li>– Lab/x-ray</li> <li>– Manipulations</li> <li>– Therapy</li> </ul> </li> </ul>	<p><b>100%</b></p> <p><b>100%</b> after \$250 copayment</p> <p><b>100%</b> after \$25 copayment per visit to primary care physician or \$50 copayment per visit to specialist</p> <p><b>100%</b></p> <p>Subject to the applicable prescription drug copayment.</p> <p><b>100%</b> after \$25 copayment per visit to primary care physician or \$50 copayment per visit to specialist</p> <p><b>100%</b></p>

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**Benefits per covered person:**

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<b>Maternity</b>	<ul style="list-style-type: none"> <li>Inpatient hospital room and board and ancillary facility services</li> <li>Newborn inpatient services</li> <li>Practitioner services</li> </ul>	<p><b>100%</b> after \$500 copayment per day for the first five days</p> <p><b>100%</b></p> <p>\$50 office visit copayment applies to initial maternity visit if billed globally</p>
<b>Newborn must be added to the plan within 31 days of birth.</b>		
<b>Lifetime Maximum</b>	Unlimited	
<b>Mental Health, Alcohol and Chemical Dependency Services</b>	<ul style="list-style-type: none"> <li>Inpatient (<i>no limits</i>) (<i>prior authorization required</i>)</li> <li>Outpatient (<i>no limits</i>)</li> </ul>	<p><b>100%</b> after \$500 copayment per day for first five days</p> <p><b>100%</b> after \$25 copayment per visit</p>
<b>Dependent Coverage</b> <i>(Dependent daughters are covered for maternity)</i>	End of the month children reach age 26	
<b>Pre-existing Conditions</b>	There is no exclusion period for the HMO plans.	
<b>Late Enrollees</b>	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the Group's anniversary date.	
<b>Detailed Benefit Information Exclusions and Limitations</b>	Call your Humana Customer Service Representative or consult your benefits booklet. The benefits booklet will govern in all cases.	
<b>Customer Service</b>	1-800-448-6262	

Logon to **Humana.com** for Provider Directories, and MyHumana.com to view your claims, create your own health record and many other powerful resources!

**Prior authorization** - Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at **Humana.com/members/tools** or call Customer Service.

Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

**Payments** - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. This

plan has one (1) level of benefits - participating provider benefits, payable as shown in the Schedule of Benefits section. You are responsible for any applicable copayment amount.

When receiving services, you should make sure the provider is a participating provider for this Plan. Humana may designate limited panels of participating providers from which certain kinds of services must be obtained. If these services are not obtained from the designated participating providers, benefits for these services may be denied. Humana reserves the right, at their discretion, to make changes to the list of participating providers at any time.

**Participating primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made**

**by the physicians or other providers listed in network directories or otherwise selected by you.**

**To be covered, expenses must be medically necessary and specified as covered. Please see your Plan Document for more information on medical necessity and other specific plan benefits.**

(1) Coverage may be subject to specific age, frequency or medical history requirements.

*The amount of benefit provided depends upon the plan selected. Premiums will vary according to the selection made.*

*For general questions about the plan, contact your benefits administrator.*



Administered by Humana Insurance Company

# Benefit summary changes due to *federal health care reform*

The Patient Protection and Affordable Care Act, also known as federal healthcare reform, became law on March 23, 2010. Because of this law, health plans sold or renewed with an effective date on or after Sept. 23, 2010 must meet certain guidelines. Here's an overview of federal healthcare reform updates to your benefit summary.

## **Preventive services**

The plan covers in-network preventive care services at 100 percent – you will not pay a copayment, coinsurance, or deductible.

For more details please reference your benefit plan booklet or visit [healthcare.gov](http://healthcare.gov).

## **Lifetime maximum benefits**

The plan has an unlimited lifetime maximum.

## **Transplant Benefits**

The plan has an unlimited transplant maximum.

## **Annual dollar limits**

There are no annual dollar limits on covered essential health benefits, which include the following:

- **Ambulatory patient services**
- **Emergency services**
- **Hospitalization**
- **Maternity and newborn care**
- **Mental and substance use disorder, including behavioral health treatment**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices**
- **Laboratory services**
- **Preventive and wellness services and chronic disease management**
- **Pediatric services, including oral and vision care**

## **Emergency care**

The plan covers services for an emergency medical condition provided in a hospital's emergency facility at the in-network benefit level.

## **Extend Dependent Age to age 26**

All dependents are eligible to the end of the calendar month in which they turn age 26, regardless of student, marital or employment status.

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