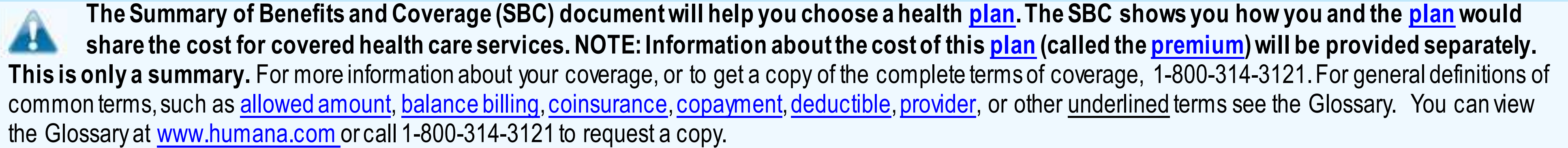
Humana: POS Deluxe 15

American Airlines (Active)

Coverage for: Individual, Family | **Plan Type:** POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 1-800-314-3121. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.humana.com or call 1-800-314-3121 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	You don't have to meet deductibles.
Are there other deductibles for specific services?	Yes, For Out-of-Network providers $100 Individual; $300 Family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for out-of-network provider services.
What is the out-of-pocket limit for this plan?	$2000 Individual $6000 Family (In-Network)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Out-of-network services, cost-shares, premiums and not covered services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.humana.pr or call 1-800-314-3121 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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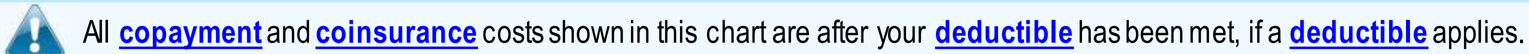
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	$17 copay/visit	Covered by reimbursement at contracted fee. $17 copay/visit	None
	Specialist visit	$20 copay/visit	$22 copay/visit	Covered by reimbursement at contracted fee. $22 copay/visit	None
	Preventive care/screening/ immunization	No copay	No copay	Covered by reimbursement at contracted fee	Based on Federal Healthcare Reform / Affordable Care Act (ACA). You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No coinsurance	No coinsurance	Covered by reimbursement at contracted fee 25% coinsurance /test	None
	Imaging (CT/PET scans, MRIs)	No coinsurance	No coinsurance	Covered by reimbursement at contracted fee 25% coinsurance /test	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com.	Generic drugs (Tier 1)	$10 copay/prescription (retail) $20 copay/prescription (mail order)		Not covered	Formulary: F50 (RX-2) Retail - Covers up to a 30-day supply. Mail order – Covers up to a 90-day supply. MAC A (Generics mandatory)
	Brand drugs (Tier 2)	$25 copay/prescription (retail) $50 copay/prescription (mail order)	$25 copay/prescription (retail) $50 copay/prescription (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No copay	$25 copay/facility	Covered by reimbursement at contracted fee. $25 copay/facility	None
	Physician/surgeon fees	No coinsurance	25% coinsurance/ surgery	Covered by reimbursement at contracted fee. 25% coinsurance/ surgery	None
If you need immediate medical attention	Emergency room care	$50 copay/illness visit $0 copay/accident visit	$60 copay/illness visit $0 copay/accident visit	Covered by reimbursement at contracted fee $60 copay/illness visit	None
	Emergency medical transportation	$0 copay/ trip between facilities $25 copay/ ground trip 50% coinsurance/ air or maritime trip	$0 copay/ trip between facilities $25 copay/ ground trip 50% coinsurance/ air or maritime trip	Covered by reimbursement at contracted fee. $0 copay/ trip between facilities $25 copay/ ground trip 50% coinsurance/ air or maritime trip	Maritime and air aerial transportation (within the territorial limits of P.R.) and air transportation between U.S. and P.R. is covered after preauthorization, unless the nature of the emergency does not allow it.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
	Urgent care	$50 copay/illness visit $0 copay/accident visit	$60 copay/illness visit $0 copay/accident visit	Covered by reimbursement at contracted fee $60 copay/illness visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/stay	$150 copay/stay	Covered by reimbursement at contracted fee $150 copay/stay	Pre-notification is not required for admissions through emergency. Excluded: Private room, expenses related to personal convenience, private nurse, unless in cases previously approved by Humana; personal use items, such as television, phone or "admission kit".
	Physician/surgeon fees	No coinsurance	25% coinsurance/ surgery	Covered by reimbursement at contracted fee. 25% coinsurance/ surgery	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	$22 copay/visit	Covered by reimbursement at contracted fee. $22 copay/visit	None
	Inpatient services	$100 copay/stay	$150 copay/stay	Covered by reimbursement at contracted fee $150 copay/stay	
If you are pregnant	Office visits	$15 copay/visit	$17 copay/visit	Covered by reimbursement at contracted fee. $17 copay/visit	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay may apply. Maternity care

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
	Childbirth/delivery professional services	No coinsurance	25% coinsurance/ surgery	Covered by reimbursement at contracted fee. 25% coinsurance/ surgery	may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$100 copay/stay	$150 copay/stay	Covered by reimbursement at contracted fee $150 copay/stay	
If you need help recovering or have other special health needs	Home health care	No coinsurance	25% coinsurance/ surgery	Covered by reimbursement at contracted fee. 25% coinsurance/ surgery	Services must start in the first 30 days after the discharge from the hospital or skilled nursing facility and may be provided in substitution of an admission. Preauthorization is required. Home health services may include services described elsewhere in the SBC (i.e. specialist visit, physical therapy).
	Rehabilitation services	No coinsurance for therapies. $20 copay/chiropractor visit	25% coinsurance/ therapy session. $22 copay/chiropractor visit	Covered by reimbursement at contracted fee 25% coinsurance/ therapy session. $22 copay/chiropractor visit	Rehabilitation services, including speech therapy, occupational therapy and physical therapy, are covered for conditions subject to improve within sixty (60) days. Pre-autorización required. Chiropractic services are covered fifteen (15) manipulations, per subscriber per contract year.
	Habilitation services	No coinsurance for therapies. $20 copay/chiropractor visit	25% coinsurance/ therapy session. $22 copay/chiropractor	Covered by reimbursement at contracted fee	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
			visit	25% coinsurance/ therapy session. $22 copay/chiropractor visit	
	Skilled nursing care	No copay	$25 copay/facility	Covered by reimbursement at contracted fee. $25 copay/facility	Maximum sixty 60 days per subscriber in lifetime. Must comply with medical necessity.
	Durable medical equipment	50% coinsurance/ equipment	50% coinsurance/ equipment	Covered by reimbursement at contracted fee 50% coinsurance/ equipment	Preauthorization is required.
	Hospice services	No coinsurance	25% coinsurance/ surgery	Covered by reimbursement at contracted fee. 25% coinsurance/ surgery	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$20 copay/exam	$22 copay/exam	Covered by reimbursement at contracted fee. $20 copay/exam	One (1) refraction test per contract year.
	Children's glasses	Not covered	Not covered	Not covered	Vision discount available with Eyemed.
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Infertility Treatment • Acupuncture	• Long Term Care • Cosmetic Surgery • Private Duty Nursing	• Weight Loss Programs • Hearing Aids • Dental Care • Non-emergency care when traveling outside the U.S. (unless dependent is studying in U.S.)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric Surgery • Chiropractic Care	• Routine eye care (Adult) • Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov or you can contact the Puerto Rico Office of the Commissioner of Insurance. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact our customer service department at 1-800-314-3121.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-314-3121.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-314-3121.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-314-3121.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-314-3121.]

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$15**
- **Hospital (facility) copayment** **$100**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$6,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$325
Coinsurance	$290
What isn't covered	
Limits or exclusions	$570
The total Peg would pay is	**$1,185**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$15**
- **Hospital (facility) copayment** **$100**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$6,100**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$440
Coinsurance	$330
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$840**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$15**
- **Hospital (facility) copayment** **$100**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,200**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$150
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$210**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact 1-800-314-3121.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.