

## How the Deductible Works on the H52616-279 and H5216-345 Plans

### The following services are EXEMPT from the deductible:

- In-Network Primary Care Office Visits
- In-Network Specialist Office Visits
- In-Network Lab Services
- Urgent Care Visits
- Ambulance Services
- Emergency Room Services
- Immunizations (Flu & Pneumonia)
- Diabetic Monitoring Supplies
- Medicare Covered Part B Drugs
- Chemotherapy Drugs
- Medicare Covered Preventive Services

### What does “EXEMPT from deductible” mean?

Exempt means that insurance benefits will pay out on these services regardless of whether the deductible has been satisfied or not. For example, the member does not have to meet the deductible for a PCP office visit to be paid for by the plan.

### What are the medical services that do require meeting deductible?

Every other covered medical expense not listed in the above list must meet the medical deductible, including but not limited to:

- Inpatient/Outpatient Hospital Services
- Outpatient Surgery
- Skilled Nursing Facility Care
- Advanced Imaging
- Durable Medical Equipment
- Home Health
- Infusion Therapy
- Prosthetic Devices and Supplies
- Renal Dialysis

### How does the deductible work?

The deductible is **ANNUAL**. This means that expenses paid toward the deductible accumulate. Once the full amount of the deductible has been paid off or “satisfied” the deductible is met for the rest of the calendar year.

The member must pay the full amount of the cost of the service, until the deductible has been satisfied. If the plan has a \$500 deductible, and on January 1st, the member has a \$400 medical expense, they

must pay the full \$400. \$100 would remain on the deductible in that example. That \$100 would have to be met on the next medical expense, before insurance benefits would kick in.

Once the deductible has been **SATISFIED** then the insurance benefits kick in. Keep in mind that the other cost-sharing components will also kick in after the deductible has been met. For example, if a member has satisfied their deductible, and they have Inpatient Hospital Services, they will still need to pay their per-day hospital copays.

Summarizing, the deductible is annual, it must be satisfied before insurance benefits begin, other cost-sharing will still apply after meeting deductible, and several services on the plan are **EXEMPT** from having to meet the deductible.

### **Why does it say “combined in-network and out-of-network deductible”?**

This means that its one deductible that applies equally to both in-network and out-of-network services. Both in-network and out-of-network expenses are subject to the same deductible, and once satisfied, the insurance benefits kick in for both in-network and out-of-network services.

### **How does this all relate to the Maximum Out of Pocket (MOOP)?**

Every Medicare Advantage Plan has a stated MOOP. This is the maximum amount that a member has to pay out-of-pocket for the year. Everything the member pays out-of-pocket towards their medical expenses accumulate toward the MOOP. This includes:

- Medical Deductible
- Medical Copays
- Medical Coinsurance

All of these member out-of-pocket costs add up over the year. If the total sum of the member’s out of-pocket costs reaches the MOOP – the member will no longer have any more medical cost sharing for the rest of the year.

The MOOP is like a safety net, that states that “this amount is the most a member will pay per year, no matter how high their medical expenses are”.

**Keep in mind that the MOOP is only applicable to MEDICAL out-of-pocket costs.** Prescription Drugs are their own separate category – Rx costs do not count toward the medical MOOP, and still require their own cost-sharing if the MOOP is met.

## Here's an example scenario to help explain how this all works:

For a member that is enrolled in plan H5216-279 and has not met any of their deductible for the year.

- Member goes into the hospital and stays 5 days with a total hospital bill of **\$100,000**.
- Member pays the first **\$750** leaving a balance of **\$99,250**.
- Member will then pay **\$200** per day or **\$1,000**, leaving a balance of **\$98,250**.
- Humana will then pay the **\$98,250**.
- **\$1,750** is applied to the MOOP.

Member has a second hospitalization for 5 days.

- Member pays **\$200** per day or **\$1,000**.
- Humana pays the balance.
- **\$1,000** is applied to the MOOP for a total of **\$2,750**.