Insurance Plan Benefit Details and Comparison

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3 plans selected for comparison

Finished comparing?

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	Humana	CoventryOne	Louisiana
	Humana Connect Bronze 6300/6300 Plan ...	Bronze Deductible Only HMO Plan - LA ...	Blue Saver 70/50 $3300
	$239.57 Per month	$232.39 Per month	$269.79 Per month
	BEST SELLER	BEST SELLER	
	Apply Details	Apply Details	Apply Details
Plan Type	HMO	HMO	PPO
Metal Level	Bronze	Bronze	Bronze
Cost Calculator* (based on medical scenarios)	Minor Event (e.g. broken leg) Total Savings: $0 Mid-size Event (e.g. appendectomy) Total Savings: $9,700 Major Event (e.g. heart surgery) Total Savings: $93,700	Minor Event (e.g. broken leg) Total Savings: $0 Mid-size Event (e.g. appendectomy) Total Savings: $9,700 Major Event (e.g. heart surgery) Total Savings: $93,700	Minor Event (e.g. broken leg) Total Savings: $1,190 Mid-size Event (e.g. appendectomy) Total Savings: $9,700 Major Event (e.g. heart surgery) Total Savings: $93,700
Office Visit for Primary Doctor	No Charge after deductible Find Doctors	No charge after deductible Find Doctors	30% Coinsurance after deductible Find Doctors
Office Visit for Specialist	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible

Office Visit for Other Practitioner (Nurse, Physician Assistant)	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Annual Deductible	Individual: $6,300	Individual: $6,300	Individual: $3,300
Coinsurance	0%	0% Coinsurance	30%
Annual Out-of-Pocket Limit	Individual: $6,300 Includes deductible	Individual: $6,300 Includes deductible	Individual: $6,300 Includes deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Health Savings Account (HSA) Eligible	Yes (See HSA Administrators)	Yes (See HSA Administrators)	Yes (See HSA Administrators)
Out-of-Network Coverage	No	Emergency Care Only	Yes (Details in plan brochure below)
Out-of-Country Coverage	Yes. Out of Country Coverage is covered for any expense incurred for services received outside of the United States as required by law for emergency care services.	No.	Yes. Emergency and non-emergency coverage subject to Blue Card Worldwide rules.
Office Visit			
Primary Care Physician Required	Yes	No	No
Specialist Referrals Required	Yes	No	No
Preventive Care Coverage			
Periodic Health Exam	No Charge	$0 Copay	No Charge
Periodic OB-GYN Exam	No Charge	$0 Copay	No Charge
Well Baby Care	No Charge	$0 Copay	No Charge
Emergency and Urgent Care			
Emergency Room	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible

Emergency Ambulance Services	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Urgent Care Facility	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Prescription Drug Coverage			
Retail Prescription Drugs	Preferred Generic Drugs: No Charge after deductible; Non-Preferred Generic Drugs: No Charge after deductible; Preferred Brand Name Drugs: No Charge after deductible; Non-Preferred Brand Name Drugs: No Charge after deductible; Specialty Drugs: No Charge after deductible.	Tier 1 - Preferred Generic Drugs: No charge after deductible; Tier 2- Preferred Brand Drugs: No charge after deductible; Tier 3 - Non Preferred Brand/Generic Drugs: No charge after deductible; Tier 4 - Preferred Specialty Drugs: No charge after deductible; Tier 5 - Non Preferred Specialty Drugs: No charge after deductible	Generic Drugs: 30% Coinsurance after deductible Brand Name Drugs: 50% Coinsurance after deductible Non-Preferred Brand Drugs: 50% Coinsurance after deductible Specialty Drugs: 50% Coinsurance after deductible
Separate Prescription Drugs Deductible	Medical Plan Deductible Applies	Integrated Medical / Rx Deductible	Medical Plan Deductible Applies
Mail Order Prescription Drugs	Preferred Generic Drugs: No Charge after deductible; Non-Preferred Generic Drugs: No Charge after deductible; Preferred Brand Name Drugs: No Charge after deductible; Non-Preferred Brand Name Drugs: No Charge after deductible; Specialty Drugs: No Charge after deductible.	Tier 1 - Preferred Generic Drugs: No charge after deductible; Tier 2- Preferred Brand Drugs: No charge after deductible; Tier 3 - Non Preferred Brand/Generic Drugs: No charge after deductible; Tier 4 - Preferred Specialty Drugs: No charge after deductible; Tier 5 - Non Preferred Specialty Drugs: No charge after deductible	Generic Drugs: 30% Coinsurance after deductible Brand Name Drugs: 50% Coinsurance after deductible Non-Preferred Brand Drugs: 50% Coinsurance after deductible Specialty Drugs: 50% Coinsurance after deductible
Mail Order Supply	90	90	Three copayments cover up to a 90 Day Supply
Outpatient Coverage			
Outpatient Surgery	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Outpatient Lab/X-Ray	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible

Imaging (CT and PET scans, MRIs)	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Outpatient Mental Health	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Outpatient Substance Abuse	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Outpatient Rehabilitation Services (PT, OT, ST)	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Inpatient Coverage			
Hospitalization	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Skilled Nursing Facility	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Inpatient Mental Health	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Inpatient Substance Abuse	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Home Healthcare	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Maternity Coverage			
Pre & Postnatal Office Visit	No Charge after deductible	$0 Copay pre-natal; Deductible post-natal	30% Coinsurance after deductible
Labor & Delivery Hospital Stay	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Pediatric Services			
Dental Checkup for Children	No Charge after deductible	$0 Copay, One check-up every six months	No Charge, 1 Visit(s) per 6 Months
Vision Screening for Children	No Charge after deductible, 1 visit per year	$0 Copay, One routine eye examination per year	No Charge, 1 Visit(s) per Year
Eye Glasses for Children	No Charge after deductible, 1 item per year; 1 pair of lenses per year	No Charge after deductible- One pair of standard eyeglass lenses or contact lenses	No Charge, 1 Item(s) per Year

		per year; one frame per year	
Major Dental Coverage (Pediatric)	No Charge after deductible	50% Coinsurance	50% Coinsurance after deductible
Additional Coverage			
Chiropractic Coverage	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Durable Medical Equipment	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Hospice	No Charge after deductible	No charge after deductible	30% Coinsurance after deductible
Major Dental Coverage (Adult)	Not Covered	Not Covered	Not Covered
Vision Coverage (Adult)	Not Covered	Not Covered	Not Covered
Out-of-Network Coverage			
Out-of-Network Authorization Required	N/A	N/A	Yes
Out-of-Network Annual Deductible	N/A	N/A	Individual $6600/Family $13200
Out-of-Network Annual Coinsurance	N/A	N/A	50%
Out-of-Network Annual Out-of-Pocket Limit	N/A	N/A	Individual $12600/Family $25200
Additional Information			
A.M. Best Rating	A- as of 01/11/2013	A as of 06/13/2013	NR-5pd as of 04/26/2010
Electronic Signature for Application Available	Yes	Yes	Yes
Details and documents about this plan	View Plan Brochure Summary of Benefits & Coverage (Not available) Exclusions &	View Plan Brochure (Not available) Summary of Benefits & Coverage (Not	View Plan Brochure (Not available) Summary of Benefits & Coverage

	Exclusions & Limitations	available) The carrier has not provided a separate document for Exclusions and Limitations.	

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Chat with us anytime, 24/7

Rate, benefit, eligibility, and plan recommendation inquiries must be made over the phone. For all other inquiries, please start a live chat.

Start a Chat, 24/7 support

IMPORTANT NOTICES AND DISCLAIMERS

- **THE BENEFITS MATRIX IS A SUMMARY FOR INFORMATIONAL PURPOSES ONLY. REVIEW THE EVIDENCE OF COVERAGE AND INSURANCE POLICY (PLAN CONTRACT) FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS, LIMITATIONS, AND EXCLUSIONS. ONLY THE TERMS AND CONDITIONS OF COVERAGE BENEFITS LISTED IN THE POLICY ARE BINDING.**
- The benefits listed may be contingent on your use of physicians, hospitals, and services within the specific insurance company's provider network.
- The Copayment, Deductible, and Coinsurance amounts are your share of the costs for covered benefits. These amounts are subject to change.
- Each insurance carrier may have unique Notices, Disclaimers, and Fees. Please check below for information regarding the plans and carriers you selected.
- The quotes or rates shown above are estimates only. Your premium is subject to change based on the optional benefits you selected, if any, and other relevant factors, such as changes in rates that take effect before your coverage start date. The insurance company always determines your actual premium. Insurance companies reserve the right to change the terms of a policy upon proper notification.
- ***This is not a true cost calculator.** The actual costs of treatment you receive could vary greatly from the examples provided. Estimates for the examples listed can be seen at healthcarebluebook.com or healthcarefees.com.**Insurance expenses do not include premium payments.** Insurance expenses also assume you use in-network services and may not include items not associated with your deductible such as doctor visits, prescription drugs or hospital copays. This is not a guarantee of costs. Always check your policy details for specific information regarding your coverage.
- The Summary of Benefits & Coverage form pertains to the coverage provided by a particular health insurance plan. If you select certain optional benefits while applying for this health insurance plan, a modified Summary of Benefits & Coverage may be available that reflects the optional benefits that you selected. A paper copy of this Summary of Benefits & Coverage is available upon request by calling our toll free number. Click here to view the Uniform Glossary of Coverage and Medical Terms.

CARRIER SPECIFIC NOTICES, DISCLAIMERS, AND FEES

- *Humana* - Insured by Humana Insurance Company, Humana Health Plan, Inc., Humana Health Insurance Company of Florida, Inc., or Humana Health Benefit Plan of Louisiana, Inc., Or offered by Humana Medical Plan Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan of Texas, Inc. ,Humana Health Plan, Inc. , Humana Medical Plan of Michigan, In,. ,Humana Health Plan of Ohio, Inc., or Humana Medical Plan of Utah, Inc.
- *Humana* - For Arizona residents: Insured by Humana Insurance Company or offered by Humana Health Plan, Inc.. For Texas residents: Insured by Humana Insurance Company or offered by Humana Health Plan of Texas, Inc.
- *Humana* - 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.

- *Humana* - Insured or offered by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of Kentucky, Humana Health Insurance Company of Florida, Inc., Humana Insurance Company of New York, The Dental Concern, Inc., CompBenefits Insurance Company, CompBenefits Company, CompBenefits Dental, Inc., CompBenefits of Alabama, Inc., CompBenefits of Georgia, Inc., CompBenefits Direct, Inc., Humana Health Benefit Plan of Louisiana, Inc., DentiCare, Inc. (d/b/a CompBenefits), or Texas Dental Plans, Inc.