

KENTUCKY

HumanaPPO 08 80/50 Plan

		Plan pays for services at PARTICIPATING providers	Plan pays for services at NONPARTICIPATING providers
Preventive Care (1)	<ul style="list-style-type: none"> Routine immunizations (to age 18) Routine Pap smear Annual routine mammogram Routine lab test and X-ray Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy) Routine adult physical exam (18 years and above) Routine child exams (to age 18) 	100%	50% after deductible
Physician Services (1)	<ul style="list-style-type: none"> Office visits Diagnostic, lab and X-rays (copayment does not apply) Allergy testing (copayment does not apply) Inpatient services Outpatient services Office surgery Emergency room physician visits (2) Allergy injections and nonroutine injections other than allergy 	<p>100% after \$25 primary care physician/\$40 specialist copayment per visit</p> <p>80% after deductible</p> <p>80% after deductible</p> <p>100% after \$5 copayment per visit</p>	<p>50% after deductible</p> <p>50% after deductible</p> <p>80% after deductible</p> <p>50% after deductible</p>
Facility Services	<ul style="list-style-type: none"> Inpatient hospital care Outpatient surgery Outpatient nonsurgical care Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) Hospital emergency services (emergency room copayment waived if admitted) (2) 	<p>100% after \$150 copayment per day for five days</p> <p>100% after \$100 copayment per visit</p> <p>80% after deductible</p> <p>80% after \$150 copayment per visit</p>	<p>50% after deductible</p> <p>50% after deductible</p> <p>50% after deductible</p> <p>80% after \$150 copayment per visit</p>
Prescription Drugs	<ul style="list-style-type: none"> Member pharmacy (30-day supply) Mail order (90-day supply) 	<p>100% after: Level One – \$15 copayment Level Two – \$30 copayment Level Three – \$50 copayment Level Four – 25% copayment (up to \$2,500 maximum out-of-pocket per calendar year)</p> <p>100% after two times the applicable copayment</p>	<p>30% after applicable copayment</p> <p>30% after applicable copayment</p>
Other Medical Services (3)	<ul style="list-style-type: none"> Skilled nursing facility (up to 60 days per calendar year) Home health (up to 100 visits per calendar year) Durable medical equipment (unlimited) Physical, occupational, cognitive, speech and audiology therapy (up to combined limit for all therapy services up to 30 visits per calendar year) Urgent care facility Chiropractic services (up to 12 visits per calendar year) Ambulance (2) Transplant services 	<p>80% after deductible</p> <p>100% after \$25 copayment per visit</p> <p>100% after \$35 copayment per visit</p> <p>100% after primary care physician copayment per visit</p> <p>100%</p> <p>Same as any other covered condition when services are received from a Humana Transplant Network provider (when services are received from a Humana Transplant Network Provider)</p>	<p>50% after deductible</p> <p>50% after \$25 copayment</p> <p>50% after \$75 copayment</p> <p>50% after deductible</p> <p>100%</p> <p>Same as any other covered condition (covered expenses are limited to a maximum benefit of \$35,000 per transplant)</p>

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PARTICIPATING providers

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NONPARTICIPATING providers

Deductible and Out-of-Pocket Maximum Accumulation Methods	• Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately		
Deductible <i>(per calendar year; copayments do not apply)</i>	<ul style="list-style-type: none"> • Individual • Family (4) 	\$500 Two times individual participating deductible	Three times individual participating deductible Three times family participating deductible
Out-of-Pocket Maximum <i>(per calendar year; deductibles and copayments do apply)</i>	<ul style="list-style-type: none"> • Individual • Family 	\$2,500 Two times individual participating out-of-pocket maximum	Three times individual participating out-of-pocket maximum Three times family participating out-of-pocket maximum
Lifetime Maximum Benefit	Unlimited <i>(participating and nonparticipating combined)</i>		
Behavioral Health <i>(mental health and substance abuse)</i>	<ul style="list-style-type: none"> • Inpatient services • Outpatient therapy sessions 	Same as any other covered condition	Same as any other covered condition

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. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Certificate of Insurance.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

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 judgment 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 Certificate for more information on medical necessity and other specific plan benefits.

- (1) The following are generally defined as primary care physicians under your plan; general practitioner, family practitioner, pediatrician or internist.

- (2) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.
- (3) Visit and day limits are combined for participating and nonparticipating providers.
- (4) You are not required to meet individual deductibles once the family deductible has been met.

Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. Limitations and exclusions to coverage apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing any procedure, treatment or supply. This guide is available at Humana.com/members/enrollment-center/pre-enrollment-disclosures or through your sales representative.

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

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

The Pre-existing condition exclusion information is applicable to all PPO and Classic products. If you are considering enrollment in an HMO or POS plan, please refer to your plan summary to determine if the plan contains a pre-existing condition exclusion.

PRE-EXISTING CONDITION EXCLUSION

If the plan imposes a pre-existing condition exclusion, and you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends

the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy; genetic information in the absence of a diagnosis of the condition related to the information; or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health

coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Humana Enrollment at 2432 Fortune Drive, Lexington, KY 40509 or call 1-800-872-7207.



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. We're in the process of updating Humana benefit summaries to meet those guidelines. In the meantime, 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.

Lifetime maximum benefits

The plan has an unlimited lifetime 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**

Pre-existing conditions

The pre-existing condition limitation will no longer apply to a covered person who is under the age of 19, but continues to apply to those age 19 and older.

Emergency care

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



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Statements in languages other than English contained in the advertisement do not necessarily reflect the exact contents of the policy written in English, because of possible linguistic differences. In the event of a dispute, the policy as written in English is considered the controlling authority.

Cambios al resumen de beneficios debido a la *reforma federal al sistema de salud*

La Ley de Protección al Paciente y Cuidado de Salud de Bajo Precio, conocida también como Reforma Federal al Sistema de Salud, entró en vigencia el 23 de marzo de 2010. Según la ley, los planes de salud vendidos o renovados con vigencia el 23 de septiembre de 2010 o después, deben acatar ciertas normas. Mientras actualizamos los resúmenes de beneficios de Humana para cumplir dichas normas, le ofrecemos un boceto de las actualizaciones de la reforma federal al sistema de salud a su resumen de beneficios.

Servicios preventivos

El plan cubre los servicios de atención preventiva dentro de la red en un 100% – usted no pagará copagos, coaseguros ni deducibles.

Beneficios máximos de por vida

El plan no tiene límites de por vida para los beneficios.

Límites monetarios anuales

No hay límites monetarios anuales a los beneficios esenciales de salud cubiertos, los que incluyen:

- **Servicios para pacientes ambulatorios**
- **Servicios de emergencia**
- **Hospitalizaciones**
- **Maternidad y cuidado del recién nacido**
- **Trastornos mentales y adicciones, incluido el tratamiento de la salud del comportamiento**
- **Medicamentos recetados**
- **Servicios y dispositivos de habilitación o rehabilitación**
- **Servicios de laboratorios**
- **Servicios preventivos, de bienestar y de control de enfermedades crónicas**
- **Servicios pediátricos, incluida la atención dental y de la vista**

Afecciones médicas preexistentes

La limitación por afección preexistente ya no se aplicará a una persona cubierta menor de 19 años, pero sigue vigente para personas de 19 años de edad o mayores.

Atención médica de emergencia

El plan cubre los servicios recibidos por una afección de emergencia en un centro médico de emergencias de un hospital, con un nivel de beneficios dentro de la red.



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Los enunciados que este documento contenga en otro idioma, que no sea el inglés, podrían no manifestar rigurosamente el significado de la póliza original debido a la posibilidad de diferencias lingüísticas. En caso de haber alguna discrepancia, la versión en inglés asumirá la validez exclusiva.

GRANDFATHERED HEALTH PLAN NOTICE

AVISO DEL PLAN DE SALUD EXENTO

Humana believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to our customer service center at the telephone number on your identification card. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Humana considera este plan como un “plan de salud exento” bajo la Ley de Protección al Paciente y Cuidado de Salud de Bajo Precio de 2010 (Affordable Care Act, en inglés). Según lo permitido por dicha ley, un plan de salud exento puede amparar cierta cobertura básica de salud que ya estaba vigente cuando la ley se decretó. Un plan de salud exento significa que su plan pudiera no incluir ciertas protecciones al consumidor de la Ley de Cuidado de Salud de Bajo Precio que se aplican a otros planes; por ejemplo, el requisito de suministrar servicios de salud preventivos sin ninguna participación del costo. Sin embargo, los planes de salud exentos deben cumplir con ciertas otras protecciones al consumidor incluidas en la Ley de Cuidado de Salud de Bajo Precio, por ejemplo, la eliminación de límites máximos de por vida a los beneficios.

Si tiene preguntas sobre cuáles protecciones se aplican a un plan de salud exento y cuáles no, o qué pudiera ocasionar que un plan cambie su categoría como plan de salud exento, llame a nuestro centro de servicio al cliente al teléfono impreso en su tarjeta de identificación. También puede comunicarse con la Administración de Seguridad de Beneficios del Empleado del Departamento de Trabajo de Estados Unidos al 1-866-444-3272 o en la página www.dol.gov/ebsa/healthreform. Este sitio Web muestra una tabla en la que se resume cuáles protecciones se aplican, o no, a los planes de salud exentos.



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