

OHIO 2011 Major Plan Benefits		Plan pays for services provided by PARTICIPATING providers	Plan pays for services provided by NONPARTICIPATING providers
Preventive Care	<ul style="list-style-type: none"> Immunizations Mammogram and Pap smear Adult routine physical exam (<i>one per plan year</i>) Well-child care Well-woman exam 	100%	60% after deductible
Physician Services	<ul style="list-style-type: none"> Office visits in conjunction with a sickness or injury Diagnostic tests, lab and X-rays (<i>when billed as an in-office procedure</i>) Allergy tests/serum Office surgery Physician visits to emergency room (1) Allergy injections Inpatient services Outpatient services Office therapy/chiropractic adjustment (<i>up to 12 visits per calendar year</i>) 	100% after \$20 copayment to primary care physician or \$40 copayment to specialist 100% 80% after deductible 100% after \$40 specialist copayment	60% after deductible 60% after deductible 60% after deductible 60% after deductible
Hospital Services	<ul style="list-style-type: none"> Inpatient care (<i>semiprivate room and ancillary services</i>) Outpatient surgery Outpatient nonsurgical care Emergency room 	80% after deductible 100% after \$150 copayment (<i>waived if admitted</i>) (1)	70% after applicable copayment 100% after \$150 copayment (<i>waived if admitted</i>) (1)
Prescription Drugs	<ul style="list-style-type: none"> Retail pharmacy (Rx4) (<i>30-day supply</i>) Mail order (Rx4) (<i>90-day supply</i>) 	100% after: Level One – \$10 copayment Level Two – \$30 copayment Level Three – \$50 copayment Level Four – 25% 100% after: Level One – \$20 copayment Level Two – \$60 copayment Level Three – \$100 copayment Level Four – 25%	70% after applicable copayment Not covered
Other Medical Services	<ul style="list-style-type: none"> Skilled nursing facility (<i>up to 120 days per plan year</i>) (2) Home health care (<i>up to 30 visits per plan year</i>) (2) Durable medical equipment (2) Hospice services (2) Physical and occupational therapy (<i>up to 60 visits per calendar year</i>) Speech therapy (<i>up to 20 visits per calendar year</i>) Urgent care facility 	80% after deductible 100% 100% after \$20 copayment 100% after \$20 copayment 100% after \$35 copayment	60% after deductible 60% after deductible 60% after deductible 60% after deductible
Deductible	<ul style="list-style-type: none"> Individual Family 	\$750 \$1,500	\$1,000 \$2,000
Maximum Out-Of-Pocket Expense Limit <i>(excludes deductible)</i>	<ul style="list-style-type: none"> Individual Family 	\$2,000 \$4,000	\$4,000 \$8,000
Lifetime Maximum Benefit	<ul style="list-style-type: none"> Per member benefit paid by plan 		Unlimited
Behavioral Health <i>(mental health and substance abuse services)</i>	<ul style="list-style-type: none"> Inpatient-covered services Outpatient and office therapy-covered services 	80% after deductible 100% after a \$40 copayment per visit	60% after deductible 60% after deductible

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/](https://www.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 - Plan pays benefits based on maximum allowable fees as defined in your Certificate. Participating providers agree to accept maximum allowable fees, as listed in negotiated payment schedules, as payment in full.

For services rendered by nonparticipating physicians, the member is responsible for charges exceeding a fee schedule selected by your employer and defined in your Summary Plan Description. For services from other nonparticipating providers, the member is responsible for amounts which exceed maximum allowable fees, as defined in your Summary Plan Description.

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 Summary Plan Description for more information on medical necessity and other specific plan benefits.

- (1) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Summary Plan Description.
- (2) Failure to preauthorize may result in denial of payment.

For general questions about the plan, contact your Human Resources office.

HUMANA[®]
Guidance when you need it most

This is a brief plan description. It is not the plan document and does not include all of the benefits, limitations and exclusions of the plan. More complete terms of the plan are contained in the Summary Plan Description.

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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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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