

OHIO Traditional Plan 90/50 Plan		Member pays for services at PARTICIPATING providers	Member 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) 	No copayment	50% after deductible	
	<ul style="list-style-type: none"> Routine adult physical exam (18 years and above) Routine child exams (to age 18) 	\$25 copayment per visit	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) Office surgery 	\$25 copayment per visit	50% after deductible	
	<ul style="list-style-type: none"> Inpatient services Outpatient services (includes surgery) 	10%	50% after deductible	
	<ul style="list-style-type: none"> Emergency room physician visits (2) 	No copayment	No copayment	
	<ul style="list-style-type: none"> Allergy injections and nonroutine injections other than allergy 	No copayment	50% after deductible	
Facility Services	<ul style="list-style-type: none"> Inpatient hospital care Outpatient surgery Outpatient nonsurgical care (does not include advanced imaging) Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) 	10%	50% after deductible	
	<ul style="list-style-type: none"> Hospital emergency services (emergency room copayment waived if admitted) (2) 	\$100 copayment per visit	\$100 copayment per visit	
Prescription Drugs (includes oral contraceptives)	<ul style="list-style-type: none"> Please see attached pharmacy benefit information 			
Other Medical Services (3)	<ul style="list-style-type: none"> Skilled nursing facility (subject to 100 day limits per calendar year) Home health <ul style="list-style-type: none"> participating providers (unlimited) nonparticipating providers (30 visit limit per calendar year) 	10%	50% after deductible	
	<ul style="list-style-type: none"> Speech therapy (20 visits per calendar year) Physical and occupational therapy (60 visits per calendar year) Acupuncture (20 visits per calendar year) Cognitive (unlimited) Chiropractic services (subject to 20 visits per calendar year) 	\$25 copayment per visit	50% after deductible	
	<ul style="list-style-type: none"> Durable medical equipment 	20%	50% after deductible	
	<ul style="list-style-type: none"> Urgent care facility 	\$35 copayment per visit	\$35 copayment per visit	
	<ul style="list-style-type: none"> Ambulance (2) 	No copayment	No copayment	
	<ul style="list-style-type: none"> Transplant services 	10% (when services are received from a Humana Transplant Network provider)	50% after deductible (covered expenses are limited to a maximum benefit of \$35,000 per transplant)	
	Deductible and Out-of-Pocket Maximum Accumulation Methods	<ul style="list-style-type: none"> Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately 		
	Deductible (per calendar year; copayments do not apply)	<ul style="list-style-type: none"> Individual Family (5) 	\$0 \$0	\$5,000 \$10,000

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Out-of-Pocket Maximum (per calendar year; copayments apply)	• Individual	\$1,250	Unlimited
	• Family	\$2,500	Unlimited
Lifetime Maximum Benefit		Unlimited (participating and nonparticipating combined)	
Behavioral Health (mental health and substance abuse) (3) (4)	• Inpatient services (subject to 30 days per calendar year)	10%	50% after deductible
	• Outpatient therapy sessions (subject to 50 visits per calendar year)	\$25 copayment per visit	50% 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/ or call Customer Service.

Failure to obtain necessary preauthorization when required may result in a \$500 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 Summary Plan Description.

* 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 Summary Plan Description 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 Summary Plan Description.
- (3) Visit and day limits are combined for participating and nonparticipating providers.
- (4) Biologically-based mental illness (BMI) is covered same as any other illness.
- (5) For other than single coverage, the family deductible applies. The single deductible applies to single coverage policies only.

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.

