

<b>TENNESSEE</b>		Plan pays for services at	Plan pays for services at
<b>National POS Copayment 80/50 Plan</b>		<b>PARTICIPATING</b> providers	<b>NONPARTICIPATING</b> providers
<b>Preventive Care</b> (1)	<ul style="list-style-type: none"> <li>Routine immunizations (to age 18)</li> <li>Routine Pap smear</li> <li>Annual routine mammogram</li> <li>Routine lab test and X-ray</li> <li>Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)</li> <li>Routine adult physical exam (18 years and above)</li> <li>Routine child exams (to age 18)</li> </ul>	<b>100%</b>	Not covered
<b>Physician Services</b> (1)	<ul style="list-style-type: none"> <li>Office visits</li> <li>Inpatient services</li> <li>Outpatient services</li> <li>Diagnostic lab &amp; X-ray</li> <li>Allergy testing</li> <li>Office surgery</li> <li>Allergy injections and nonroutine injections other than allergy</li> <li>Emergency room physician visits (2)</li> </ul>	<b>100%</b> after \$15 primary care physician/ \$25 specialist copayment per visit  <b>80%</b> after deductible  <b>80%</b> after deductible	<b>50%</b> after deductible  <b>50%</b> after deductible  <b>80%</b> after deductible
<b>Facility Services</b>	<ul style="list-style-type: none"> <li>Inpatient hospital care</li> <li>Outpatient surgery</li> <li>Outpatient nonsurgical care</li> <li>Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)</li> <li>Hospital emergency services (emergency room copayment waived if admitted)</li> </ul>	<b>80%</b> after deductible  \$100 copayment per visit, then 80% after deductible (1)	<b>50%</b> after deductible  \$100 copayment per visit, then 80% after deductible (1)
<b>Prescription Drugs</b> (includes oral contraceptives)	<ul style="list-style-type: none"> <li>Please see attached pharmacy benefit information, if applicable</li> </ul>		
<b>Other Medical Services</b> (3)	<ul style="list-style-type: none"> <li>Skilled nursing facility (subject to 60 day limits per calendar year)</li> <li>Home health (unlimited)</li> <li>Chiropractic, physical, occupational, cognitive, speech and audiology therapy (subject to separate limits for all therapy services - 25 visit limit for each; additional physical therapy 25 visit limit post surgery)</li> <li>Durable medical equipment (unlimited)</li> <li>Urgent care facility</li> <li>Ambulance (2)</li> <li>Transplant services</li> </ul>	<b>80%</b> after deductible  Same as specialist copayment per visit  <b>80%</b> after deductible  Same as any other covered condition when services are received from a Humana Transplant Network provider	<b>50%</b> after deductible  <b>50%</b> after participating deductible  Same as any other covered condition when services are received from a Humana Transplant Network provider (covered expenses are limited to a maximum benefit of \$35,000 per transplant)
<b>Deductible and Out-of-Pocket Maximum Accumulation Methods</b>	<ul style="list-style-type: none"> <li>Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately</li> </ul>		
<b>Deductible</b> (per calendar year; copayments do not apply)	<ul style="list-style-type: none"> <li>Individual</li> <li>Family (4)</li> </ul>	\$500 \$1,500	\$500 \$1,500
<b>Out-of-Pocket Maximum</b> (per calendar year; deductibles and copayments do not apply)	<ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$2,000 \$6,000	\$4,000 \$12,000
<b>Lifetime Maximum Benefit</b>			Unlimited

**Behavioral Health**  
(substance abuse and  
mental health)

- Inpatient services
- Outpatient therapy sessions

Same as any other illness

Same as any other illness

**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/](http://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 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) You are not required to meet individual deductibles once the family deductible has been met.

*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.*

**PRE-EXISTING CONDITION EXCLUSION**

The plan imposes a pre-existing condition exclusion. If you have a medical condition before coming to our plan, you will be required 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.

# HUMANA®

Administered by Humana Insurance Company

## How the Rx3 structure works

When you present your membership card at a participating pharmacy, you will be required to make a copayment for your prescriptions based on the type of medication you purchase:

- **Level One:** Lowest copayment for low-cost generic drugs.
- **Level Two:** Higher copayment for higher-cost brand-name drugs. \*
- **Level Three:** Highest copayment for higher-cost drugs, both generic and brand-names. These drugs may have generic or brand-name alternatives in Levels One or Two.\*

\* If you request a brand-name drug when a generic equivalent is available, you pay the applicable generic copayment, plus the cost difference between the brand-name and generic drugs. If your doctor indicates that a generic drug cannot be substituted by writing “Dispense as Written” on your prescription, you can only receive that specific drug, even if a generic equivalent is available. As a result, you will be charged the applicable brand-name copayment. In this case, you will not be responsible for the cost difference between the brand and generic. If you discover at the pharmacy that your doctor gave you a “Dispense as Written” prescription, you can ask the pharmacist to contact your doctor for approval of a generic equivalent.

Prescription drug products, or classes of certain prescription drug products, are generally reviewed on an ongoing basis by a Humana Pharmacy and Therapeutics committee, which is composed of physicians and pharmacists. Drugs are reviewed for safety, effectiveness and cost-effectiveness prior to assignment or a change in assignment to one of the levels. Coverage of a prescription drug or placement of the drug within a level are subject to change throughout the year. If drugs are moved to categories with higher member cost, advance notice is provided based on past usage. Always discuss prescription drugs with your doctor to determine appropriateness or clinical effectiveness.

Some drugs in all levels may be subject to dispensing limitations, based on age, gender, duration or quantity. Additionally, some drugs may need prior authorization in order to be covered. In these cases, your physician should contact Humana Clinical Pharmacy Review at 1-800-555-CLIN (2546).

Members can visit Humana’s Website, **Humana.com**, to obtain information about their prescription drug and corresponding benefits and for possible lower cost alternatives, or they can call Humana’s Customer Service with questions or to request a partial Humana Rx3 Drug List by mail.

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## Coverage at participating pharmacies

When you present your membership card at a participating pharmacy, you are required to make a copayment for each prescription based on the current assigned level of the drug.

Drugs assigned to:	Copayment per prescription or refill
Level One:	\$10
Level Two:	\$35
Level Three:	\$55

- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.
- If the dispensing pharmacy’s charge is less than the corresponding copayment, you will only be responsible for the lower amount.

There are no claim forms to file if you use a participating pharmacy and present your membership card with each prescription.

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## Nonparticipating pharmacy coverage\*

You may also purchase prescribed medications from a nonparticipating pharmacy. You will be required to pay for your prescriptions according to the following rule:

- You pay 100 percent of the actual charges
    - You file a claim form with Humana (address is on the back of ID card)
    - Claim is paid at 70 percent of the default rate, after it is first reduced by the applicable copayment.
  - Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.
- \* In Georgia, the nonparticipating benefits are paid the same as the participating benefits, per state regulation

## Coverage specifics

Your coverage includes the following:

- A 30-day supply or the amount prescribed, whichever is less, for each prescription or refill
- Contraceptives
- For Arizona, coverage also includes FDA approved contraceptive devices
- Certain self-administered injectable drugs approved by Humana will be paid at the applicable copayment
- Certain drugs, medicines or medications that under federal or state law may be dispensed only by prescription from a physician.

Some drugs may be subject to prior authorization requirements for coverage under the plan. Additionally, some drugs may have dispensing limitations, which limit coverage based on duration, age, gender or dosage criteria. To determine whether a drug prescribed for you may be affected by these coverage limitations, please contact Customer Service or visit our Website.

For a complete listing of participating pharmacies, please refer to your participating provider directory, or visit our Website at **Humana.com**.

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## Mail-order and 90-day Retail

For your convenience, you can receive a maximum 90-day supply per prescription or refill (maximum 30-day supply for self-administered injectable and specialty drugs)\* for certain maintenance drugs. In these cases, multiple copayments will usually apply. The same requirements apply whether purchasing medications through a participating mail-order pharmacy or purchasing in person at a retail pharmacy. Some retail pharmacies may not dispense on 90-day basis. Members can call Customer Service or visit our Website for more information, including mail-order forms.

\* See Specialty Drug Benefit flyer where applicable.

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## Definition of terms

- Brand-name medication (drug): a medication that is manufactured and distributed by only one pharmaceutical manufacturer or as defined by the national pricing standard used by Humana.
- Default rate: the rate or amount equal to the Medicare reimbursement rate for the prescription or refill.
- Copayment: the amount to be paid by the member toward the cost of each separate prescription or refill of a covered drug when dispensed by a pharmacy.
- Generic medication (drug): a medication that is manufactured, distributed, and available from several pharmaceutical manufacturers and identified by the chemical name or as defined by the national pricing standard used by Humana.
- Participating pharmacy: a pharmacy that has signed a direct agreement with us or has been designated by us to provide covered pharmacy services, covered specialty pharmacy services; or covered mail order pharmacy services, as defined by us, to covered persons, including covered prescriptions or refills delivered through the mail.
- Nonparticipating pharmacy: a pharmacy that has not been designated by us to provide services to covered persons.

## Limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

- Any drug prescribed for a sickness or bodily injury not covered under the master group contract or policy.
- Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any experimental or investigational drug, medicine or medication, even though a charge is made to you. {WI – This does not apply to those investigational drugs which are approved by the FDA for treatment of HIV infection or a medical condition arising from or related to, and that has completed a Phase III clinical investigation, }
- Anorectic or any drug used for the purpose of weight control.
- Any drug used for cosmetic purposes, including but not limited to {IN -remove but not limited to}:
  - Tretinoin, e.g. Retin A, except if you are under the age of 45 or are diagnosed as having adult acne;
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents, e.g. Solaquin.
- Any drug or medicine that is:
  - Lawfully obtainable without a prescription (over the counter drugs), except insulin {LA ~ insulin covered under diabetes benefit}; or
  - Available in prescription strength without a prescription.
- Abortifacients (drugs used to induce abortions),
- Infertility services including medications. {IL -This exclusion is removed.} {OH -Medications for infertility services.} {TX - Fertility medications.}
- Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra.
- Any drug for which prior authorization is required, as determined by us, and not obtained.
- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies. programs, services or medications. {IN - remove but not limited to }
- Treatment for onychomycosis (nail fungus).

- Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail-order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill.
- Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does not participate in our program which allows you to receive a 90-day supply of a prescription or refill.
- Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us.
- Legend drugs which are not deemed medically necessary by us.
- More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner.)

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply or prescription. This does not prevent your health care practitioner or pharmacist from providing or performing the procedure, service, treatment, supply or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.

**This is only a partial list of limitations and exclusions. Please refer to the Benefit Plan Document for complete details regarding prescription drug coverage.**

# HUMANA®

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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.

For Arizona residents: offered by Humana Health Plan, Inc. or insured by Emphesys Insurance Company or insured or administered by Humana Insurance Company

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance or Summary Plan Description) for more information on the company providing your benefits.

Our health benefit plans have limitations and exclusions

# 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.

# HUMANA®

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