Humana National POS
Summitt Trucking LLC Plan 2

HUMANA
Guidance when you need it most

INDIANA
National POS Copayment 80/50 Plan

		Plan pays for services at **PARTICIPATING** providers	Plan pays for services at **NONPARTICIPATING** providers
Deductible and Out-of-Pocket Maximum Accumulation Methods	• Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately		
Deductible *(per calendar year; copayments do not apply)*	• Individual	$3,000	$9,000
	• Family (4)	$6,000	$18,000
Out-of-Pocket Maximum *(per calendar year; deductibles and copayments do not apply)*	• Individual	$2,000	$4,000
	• Family	$4,000	$8,000
Preventive Care (1)	• Routine immunizations *(to age 18)* • Routine Pap smear • Annual routine mammogram • Routine lab test and X-ray • Preventive endoscopy *(includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)*	**100%**	**50%** after deductible
	• Routine adult physical exam *(18 years and above)* • Routine child exams *(to age 18)*	**100%** after office visit copayment	**50%** after deductible
Physician Services (1)	• Office visits • Diagnostic, lab and X-rays *(copayment does not apply)* • Allergy testing *(copayment does not apply)*	**100%** after $35 primary care physician/ $50 specialist copayment per visit	**50%** after deductible
	• Inpatient services • Outpatient services *(includes surgery)* • Office surgery	**80%** after deductible	**50%** after deductible
	• Emergency room physician visits (2)	**100%**	**100%**
	• Allergy injections and nonroutine injections other than allergy	**100%** after $5 copayment per visit	**50%** after deductible
Facility Services	• Inpatient hospital care • Outpatient surgery • Outpatient nonsurgical care *(does not include advanced imaging)* • Outpatient advanced imaging *(PET, MRI, MRA, CAT, SPECT)*	**80%** after deductible	**50%** after deductible
	• Hospital emergency services *(emergency room copayment waived if admitted)* (2)	**100%** after $200 copayment per visit	**100%** after $200 copayment per visit
Prescription Drugs (5)	• Retail pharmacy *(30-day supply)*	**100%** after Level One - $10 copayment Level Two - $40 copayment Level Three - $65 copayment Level Four - 25% copayment	**70%** after Level One - $10 copayment Level Two - $40 copayment Level Three - $65 copayment Level Four - 25% copayment
	• Mail order pharmacy *(90-day supply)*	**100%** after two times the applicable copayment	Not covered
	The total maximum out-of-pocket copayment costs for drugs in Level Four is limited to $2,500 per calendar year, per member. Smoking cessation drugs covered under applicable copayment.		
Behavioral Health *(mental health and substance abuse)*	• Inpatient services • Outpatient therapy sessions	Same as any other illness	Same as any other illness
Other Medical Services (3)	• Skilled nursing facility *(subject to 60 day limits per calendar year)* • Home health *(subject to 60 visits per calendar year)* • Physical, occupational, cognitive, speech and hearing therapy *(subject to combined limit for all therapy services up to 60 visits per calendar year)*	**80%** after deductible	**50%** after deductible

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Other Medical Services (3) *(Continued)*	• Durable medical equipment *(limited to $5,000)*	**80%** after deductible	**50%** after deductible
	• Urgent care facility	Same as specialist copayment per visit	**50%** after deductible
	• Chiropractic services *(25 visits per calendar year)*	**100%** after primary care office visit copayment per visit	**50%** after deductible
	• Ambulance	**80%** after deductible	**80%** after deductible
	• Transplant services	**80%** after deductible *(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)*
Lifetime Maximum Benefit		$1,000,000 *(participating and nonparticipating combined)*	

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.
(5) The levels are organized as follows:
- **Level One:** lowest copayment for low cost generic and brand-name drugs.
- **Level Two:** higher copayment for higher cost generic and brand-name drugs.
- **Level Three:** higher copayment than Level Two for higher cost, brand-name drugs that may have generic or brand-name alternatives on Levels One or Two.
- **Level Four:** highest copayment for high-technology drugs (certain brand-name drugs, biotechnology drugs and self-administered injectable medications).

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.

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 9 months (15 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 9-month (or 15-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 pre-existing condition exclusion and credible coverage should be directed to Humana Enrollment at 2432 Fortune Drive, Lexington, KY 40509 or 1-800-872-7207.

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