Humana National POS
Xavier University - $300 Deductible Plan

OHIO

<table>
<thead>
<tr>
<th>NATIONAL POS COPAYMENT 90/60 PLAN</th>
<th>PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS</th>
<th>PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine immunizations (to age 18)</td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>• Routine Pap smear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual routine mammogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine lab test and X-ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)</td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>• Routine adult physical exam</td>
<td></td>
<td></td>
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<tr>
<td>(18 years and above)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine child exams (to age 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine vision exam including refraction</td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

| Physician Services (1)          |                                               |                                               |
| • Office visits                  | 100% after $20 primary care physician/        | 60% after deductible                          |
|                                 | $40 specialist copayment per visit          |                                               |
| • Diagnostic, lab and X-rays (copayment does not apply) | 90%                                          | 60% after deductible                          |
| • Allergy testing (copayment does not apply) | 90% after deductible | 60% after deductible |
| • Inpatient services            | 90% after deductible                         | 60% after deductible                          |
| • Outpatient services (includes surgery) | 90% after deductible | 60% after deductible |
| • Office surgery                |                                               |                                               |
| • Emergency room physician visits (2) | 100%                                          | 100%                                          |
| • Allergy injections and nonroutine injections other than allergy | 100% after $5 copayment per visit | 60% after deductible |

| Facility Services               |                                               |                                               |
| • Inpatient hospital care       | 90% after deductible                         | 60% after deductible                          |
| • Outpatient surgery            |                                               |                                               |
| • Outpatient nonsurgical care (does not include advanced imaging) | 90% after deductible | 60% after deductible |
| • Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) | 90% after deductible | 60% after deductible |

(1) The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician, internist, or OB/GYN.
(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.
### Facility Services (continued)
- Hospital emergency services (emergency room copayment waived if admitted) (2)  
  100% after $150 copayment per visit  
  100% after $150 copayment per visit

### Prescription Drugs
- Please see attached pharmacy benefit information, if applicable

### Other Medical Services (3)
- Skilled nursing facility (subject to 90 day limits per calendar year)  
  90% after deductible  
  60% after deductible
- Home health (subject to 90 visit limits per calendar year)  
- Durable medical equipment (unlimited)
  100% after $40 specialist copayment per visit for physician home and office visits; 90% after deductible for outpatient services at hospital/alternative care center
- Physical, occupational, and speech therapy (subject to 20 visits per calendar year for each therapy type) (manipulation subject to 12 visits per calendar year)  
- Urgent care facility  
  100% after $35 copayment per visit  
  100% after $35 copayment per visit
- Ambulance (2)  
  90% after deductible  
  90% after deductible
- Transplant services  
  90% after deductible  
  60% after deductible (these charges do not apply to out-of-pocket limits)

### Deductible and Out-of-Pocket Maximum Accumulation Methods
- Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately

<table>
<thead>
<tr>
<th>Deductible (per calendar year; medical and pharmacy copayments do not apply)</th>
<th>Individual</th>
<th>Family (4)</th>
<th>Individual</th>
<th>Family (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300</td>
<td>$600</td>
<td>$600</td>
<td>$1,200</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Deductible/Coinsurance Maximum (per calendar year, deductible, coinsurance amounts and medical copayments apply)</th>
<th>Individual</th>
<th>Family (4)</th>
<th>Individual</th>
<th>Family (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Maximum (per calendar year; pharmacy copayments apply)</th>
<th>Individual</th>
<th>Family</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,500</td>
<td>$5,000</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Out-of-Pocket Maximum (per calendar year; deductible, coinsurance amounts, medical and pharmacy copayments apply)</th>
<th>Individual</th>
<th>Family</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,500</td>
<td>$9,000</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

### Lifetime Maximum Benefit
- Unlimited (participating and nonparticipating combined)

### Behavioral Health (mental health and substance abuse) (5)
- Inpatient services  
  Same as inpatient hospital care  
  60% after deductible
- Outpatient therapy sessions  
  100% after $20 office visit copayment  
  60% after deductible

(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.
(5) Biologically-based mental illness (BMI) is covered 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/ 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.

Participating 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.

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 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.


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 by Humana Insurance Company. 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 exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, call or write your Humana insurance agent or broker.
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.


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.

En Arizona: Ofrecido por Humana Health Plan, Inc. o asegurado por Emphesys Insurance Company o asegurado por Humana Insurance Company. Administrado por Humana Insurance Company

Consulte el Documento de beneficios del plan (Certificado de cobertura/seguro o Descripción resumida del plan) para obtener más información sobre la compañía que ofrece sus beneficios.

Nuestros planes de beneficios para la salud contienen limitaciones, exclusiones y términos, bajo los cuales, se podría montar o descontinuar la cobertura. Para conocer los costos y detalles completos de la cobertura, llame o escriba a su agente o corredor de seguros.