Your Health Benefits

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Relationships are built on trust. Respect for an individual's privacy goes a long way toward building trust. Humana values our relationship with you, and we take your personal privacy seriously. Humana's Notice of Privacy Practices outlines how Humana may use or disclose your personal and health information. It also tells how we protect this information. The notice provides an explanation of your rights concerning your information, including how you can access this information and how to limit access to your information. In addition, it provides instructions on how to file a privacy complaint with Humana or to exercise any of your rights regarding your information.

If you'd like a copy of Humana's Notice of Privacy Practices, you can request a copy by:

- Visiting **Humana.com** and clicking the Privacy Practices link at the bottom of the home page
- E-mailing us at privacyoffice@humana.com
- Sending a written request to:
  Humana Privacy Office
  P.O. Box 1438
  Louisville, KY 40202

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.humana.com** or by calling www.humana.com or by calling 1-866-4ASSIST (427-7478) .

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$1,000 Individual / $2,000 Family** Non-Network: **$3,000 Individual / $6,000 Family** Doesn't apply to prescription drugs and network preventive services. Co-insurance and co-payments don't count toward the deductible	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses	Yes. For Network providers **$4,500 Individual / $9,000 Family** For Non-Network providers **$6,000 Individual / $12,000 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance-billing charges, Health care this plan doesn't cover, Penalties, Non-network transplant, non-network prescription drugs, non-network specialty drugs	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.humana.com or call 1-866-4ASSIST (427-7478)** for a list of Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Questions: Call www.humana.com or by calling 1-866-4ASSIST (427-7478) or visit us at **www.humana.com**

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call www.humana.com or by calling 1-866-4ASSIST (427-7478) to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	50% coinsurance	----------none----------
	Specialist visit	$55 copay/visit	50% coinsurance	----------none----------
	Other practitioner office visit	Chiropractor Exam: $40 copay/visit	Chiropractor Exam: 50% coinsurance	----------none----------
	Preventive care / screening / immunization	No charge	50% coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.humana.com.** Click here	Level 1 - Lowest cost generic and brand-name drugs	$15 copay (Retail) $37.50 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order) Non-network cost sharing does not count toward the out-of-pocket limit.
	Level 2 - Higher cost generic and brand-name drugs	$35 copay (Retail) $87.50 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	$55 copay (Retail) $137.50 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Specialty drugs	35% coinsurance	50% coinsurance	25% coinsurance when filled via a preferred network specialty pharmacy Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	20% coinsurance	50% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------none----------
	Urgent care	$100 copay/visit	50% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fee	20% coinsurance	50% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/visit	50% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Substance use disorder outpatient services	$40 copay/visit	50% coinsurance	----------none----------
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	----------none----------
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	60 visit limit per cal yr/plan yr Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	Rehabilitation, Physical, and Occupational Therapy: $40 copay/visit	Rehabilitation, Physical, Occupational, Speech, and Audiology	Therapies: Preauthorization may be required - if not obtained, penalty will be 50% Manipulations, Physical, Occupational, Speech, and Audiology Therapy:

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		Speech, and Audiology Therapy: $55 copay/visit	Therapy: 50% coinsurance	60 Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Audiology Therapy visits per year includes manipulations & adjustments For non-network, 10 Physical Therapy, Occupational Therapy, Cognitive Therapy, Speech Therapy, Audiology Therapy visits per year includes manipulations & adjustments
	Habilitation services	Habilitation, Physical, and Occupational Therapy: $40 copay/visit Speech, and Audiology Therapy: $55 copay/visit	Habilitation, Physical, Occupational, Speech, and Audiology Therapy: 50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	60 day limit per cal yr/plan yr Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50% for durable medical equipment $750 and over Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice service	No charge	No charge	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture, unless it is prescribed by a physician for rehabilitation purposes
- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Infertility treatment
- Long-term care
- Non-emegency care when traveling outside of the U.S
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care - spinal manipulations are covered

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:
Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478)
Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/esba/healthreform
Kentucky Department of Insurance, P.O. Box 517, Frankfort, KY 40602-0517, Phone: 502-564-3630 or 502-564-6034 or 800-595-6053, TTY: 800-648-6056, Fax: 502-564-6090, Email: David.Wilhoite@ky.gov; Rodney.Hugle@ky.gov, Website: http://insurance.ky.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,390
- **Patient pays:** $2,150

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$50
Coinsurance	$1,100
Limits or exclusions	$0
Total	**$2,150**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,580
- **Patient pays:** $1,820

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,800
Coinsurance	$0
Limits or exclusions	$20
Total	**$1,820**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$2,500 Individual / $5,000 Family** Non-Network: **$7,500 Individual / $15,000 Family** Doesn't apply to prescription drugs and network preventive services. Co-insurance and co-payments don't count toward the deductible **$500** Network benefit allowance applies before deductible. Does not apply to any member copayments, Rx, or preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses	Yes. For Network providers **$6,250 Individual / $12,500 Family** For Non-Network providers **$15,000 Individual / $30,000 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance-billing charges, Health care this plan doesn't cover, Penalties, Non-network transplant, non-network prescription drugs, non-network specialty drugs	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

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Does this plan use a network of providers?	Yes. See **www.humana.com or call 1-866-4ASSIST (427-7478)** for a list of Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	30% coinsurance	----------none----------
	Specialist visit	$55 copay/visit	30% coinsurance	----------none----------
	Other practitioner office visit	Chiropractor Exam: $40 copay/visit	Chiropractor Exam: 30% coinsurance	----------none----------
	Preventive care / screening / immunization	No charge	30% coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% coinsurance	Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.humana.com.** Click here	Level 1 - Lowest cost generic and brand-name drugs	$15 copay (Retail) $37.50 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order) Non-network cost sharing does not count toward the out-of-pocket limit.
	Level 2 - Higher cost generic and brand-name drugs	$35 copay (Retail) $87.50 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	$55 copay (Retail) $137.50 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Specialty drugs	35% coinsurance	50% coinsurance	25% coinsurance when filled via a preferred network specialty pharmacy Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	No charge after deductible	30% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	$150 copay/visit	$150 copay/visit	Copayment waived if admitted
	Emergency medical transportation	No charge after deductible	No charge after deductible	----------none----------
	Urgent care	$75 copay/visit	30% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fee	No charge after deductible	30% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/visit	30% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Substance use disorder outpatient services	$40 copay/visit	30% coinsurance	----------none----------
	Substance use disorder inpatient services	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If you are pregnant	Prenatal and postnatal care	No charge after deductible	30% coinsurance	----------none----------
	Delivery and all inpatient services	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If you need help recovering or have other special health needs	Home health care	No charge after deductible	30% coinsurance	60 visit limit per cal yr/plan yr Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	Rehabilitation, Speech, and	Rehabilitation, Physical,	Therapies:

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		Audiology Therapy: $55 copay/visit Physical, and Occupational Therapy: $40 copay/visit	Occupational, Speech, and Audiology Therapy: 30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50% Manipulations, Physical, Occupational, Speech, and Audiology Therapy: 60 visits per cal yr/plan yr, includes manipulations, adjustments, modalities For non-network, 10 visit per cal yr/plan yr, includes manipulations, adjustments, modalities
	Habilitation services	Habilitation, Speech, and Audiology Therapy: $55 copay/visit Physical, and Occupational Therapy: $40 copay/visit	Habilitation, Physical, Occupational, Speech, and Audiology Therapy: 30% coinsurance	
	Skilled nursing care	No charge after deductible	30% coinsurance	60 day limit per cal yr/plan yr Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50% for durable medical equipment $750 and over Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice service	No charge	No charge	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture, unless it is prescribed by a physician for rehabilitation purposes
- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Hearing aids, unless under age 18, then 1 per ear every 36 months
- Infertility treatment
- Long-term care
- Non-emegency care when traveling outside of the U.S
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care - spinal manipulations are covered

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:
Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478)
Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/esba/healthreform
Kentucky Department of Insurance, P.O. Box 517, Frankfort, KY 40602-0517, Phone: 502-564-3630 or 502-564-6034 or 800-595-6053, TTY: 800-648-6056, Fax: 502-564-6090, Email: David.Wilhoite@ky.gov; Rodney.Hugle@ky.gov, Website: http://insurance.ky.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,990
- **Patient pays:** $2,550

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$50
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,550**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,080
- **Patient pays:** $3,320

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,200
Copays	$1,100
Coinsurance	$0
Limits or exclusions	$20
Total	**$3,320**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Humana Vision 100

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Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	$100 allowance 20% off balance over $100	$50 allowance
Standard plastic lenses[4]		
• Single vision	$25	Up to $25
• Bifocal	$25	Up to $40
• Trifocal	$25	Up to $60
• Lenticular	$25	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$25	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	$100 allowance, 15% off balance over $100	$80 allowance
• Disposable	$100 allowance	$80 allowance
• Medically necessary	$0	$200 allowance

Humana Vision 100

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

Optional benefits

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts may be available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis [1].

[1] Thompson Media Inc.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana®

Humana Short Term Disability

Created for group with 105 eligible employees

KENTUCKY

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HumanaDisability helps you prepare financially for the unexpected. A disability could be catastrophic to your family's savings, jeopardizing future financial security. Disability coverage can be there to help pay the bills that won't go away if you're disabled by illness or accident; enabling you to concentrate on recovering and returning to work.

Coverage	Options	Description
Contribution	Contributory	Employee pays all or a share of the premium.
Benefit selection Benefit percentage	50%	The employee will receive payments at the percentage up to the weekly benefit maximum.
Weekly benefit maximum	$1,000	Maximum benefits will be paid weekly if employee meets the definition of disability. Based on the top five salaries of the group, only available if benefit percentage option is selected.
Elimination period Accident benefits begin	15th day	Number of consecutive days after becoming disabled when the benefit becomes payable.
Sickness benefits begin	15th day	Example: elimination period selected is 1st day accident / 8th day sickness. The insured will be covered on the first day if unable to work due to an accident. The insured will be covered on the 8th day if unable to work due to a sickness under doctor's orders.
Definition of disability		If Disabled and Working the Employee is prevented from performing one or more essential duties of his or her occupation and earning more than 20% but no more than 80% of Pre-disability Earnings. If Totally Disabled the Employee is unable to perform the essential duties of his or her occupation and earning less than 80% of Pre-Disability Earnings.
Benefit duration	26 weeks	The length of time disability payments will be made to the employee.
Pre-existing condition limitation (in months)	Look-back / insured 12/12	A pre-existing condition is any injury or sickness the employee received medical care for. Look-back period: number of months before the effective date to determine if a medical condition is considered pre-existing. Insured period: waiting period, beginning with the effective date of coverage, before the pre-existing condition is covered.

Humana Short Term Disability

Additional plan details

Rate guarantee	Rate is guaranteed not to change for two years.
Coverage basis	Non occupational or disability that is not job related.
Residual disability benefit	This benefit does not require the employee to be totally disabled in order to qualify for benefit payments. An employee could work part-time in their own or any occupation and still be eligible for short term disability benefits at the end of the elimination period. The employee would be considered partially disabled once the short term disability benefits are payable.
Minimum enrollment	Groups must maintain enrollment of at least 10 employees to remain eligible for coverage at renewal.
Continuation during a family or medical leave	This option allows employees to continue the coverage for those who qualify under the Family and Medical Leave Act of 1993. The coverage can continue for up to 12 weeks or longer depending on state law.

All plans and options are subject to Underwriting. Approval prior to case acceptance.

Age	Rate per $1,000
0-24	$0.74
25-29	$0.70
30-34	$0.70
35-39	$0.59
40-44	$0.54
45-49	$0.59
50-54	$0.66
55-59	$0.75
60-64	$0.84
65+	$0.92

Questions?

Check out Humana.com

Call 1-800-584-4214 from 9 a.m. – 5:30 p.m. Monday – Friday, Eastern time, for a customer service representative.

Insured by Kanawha Insurance Company

This is not a complete disclosure of plan qualifications, limitations and exclusions. Please see the actual policy for complete details. Benefits may vary by state and may not be approved in all states.

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1-800-233-4013 (eligibility and benefits) | 1-800-957-7121 (claims) | Humana.com

Policy Number: 7012 9/05 or 1689

Plan summary created on: 11/10/15 09:33

Individual product base

Humana Accident

HUMANA. Specialty Benefits

Kentucky

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Accident coverage offers supplemental coverage for accidents, injuries, ambulance services, and accidental death. This is a plan that protects the whole family, including your spouse and children. Choose from four benefit levels, which are paid up to the benefit amount, in addition to any other coverage you have. You can further enhance your coverage with options, such as benefits for fractures and dislocations, providing even more flexibility.

Product base	Individual			
Coverage type	Accident Insurance provides off-the-job coverage for accidental injuries, hospital care, and accidental death benefits. There is no coverage for sickness. Four benefit levels available. Coverage is available to the insured, spouse, and children, and is guaranteed renewable to age 70.			
Benefit amount	❑ Level One	❑ Level Two	❑ Level Three	❑ Level Four
› **Accident medical expense:** Pays the actual expenses up to the amount selected for diagnosis or treatment by a physician or in an emergency room. ER subject to a $50 deductible.	$ 500	$ 1,000	$ 1,500	$ 2,000
› **Ambulance:** Pays actual expenses up to the amount selected if injury requires ground or air ambulance transportation.	$ 250	$ 500	$ 750	$ 1,000
› **Hospital indemnity:** Pays a benefit equal to the amount selected if an injury requires inpatient hospital confinement, including a room charge, that starts within 30 days after the accident. The benefit is limited to 30 days per accident.	$ 75	$ 150	$ 225	$ 300
› **Accidental death, dismemberment and loss of sight (AD&D):**				
Loss of life	$ 5,000	$ 10,000	$ 15,000	$ 20,000
Any combination of two or more hands, feet, or eyes	$ 5,000	$ 10,000	$ 15,000	$ 20,000
Loss of single hand, foot or eye	$ 2,500	$ 5,000	$ 7,500	$ 10,000
Multiple fingers and/or toes	$ 500	$ 1,000	$ 1,500	$ 2,000
Single finger or toe	$ 250	$ 500	$ 750	$ 1,000

Additional included benefits

Total disability premium waiver: If the insured becomes disabled before age 60 and as the result of injuries suffered in an accident, premiums will be waived after six months of total and continuous disability.

❑ **Fracture and dislocation:** Pays a benefit when a covered person suffers one of the fractures or dislocations listed. The benefit payable will equal the percentage shown, of the unit selected, for the injury. Pays 150% of the larger loss of two or more covered losses.

❑ $1,500

Fractures		Dislocations	
• Hip bone (pelvis) or femur	100%	• Hip	100%
• Vertebra	75%	• Knee (does not include dislocation of the patella)	50%
• Skull (depressed or ping-pong fracture)	65%	• Foot (does not include dislocation of the toes), ankle or shoulder	35%
• Leg (tibia or fibula)	50%	• Hand (does not include dislocation of fingers), lower jaw, wrist or elbow	20%
• Bones of the foot, ankle, kneecap, hand, wrist or forearm (radius or ulna)	40%	• Finger, toe	6%
• Lower jaw, shoulder blade, collar bone	35%		
• Upper arm, upper jaw, skull (simple, non-depressed fracture)	25%		
• Facial bones (or nose)	20%		
• Finger, toe, rib, coccyx	6%		

Portability	Yes

Underwritten by Kanawha Insurance Company, a Humana company.

This is not a complete disclosure of plan qualifications and limitations. Please access our website to obtain a completed list for the Workplace Voluntary Benefit products at **Disclosure.Humana.com**. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made.

Policy: 60830 9/03
Underwritten by Kanawha Insurance Company

Individual product base

Humana Accident

HUMANA. Specialty Benefits

Kentucky

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Eligibility	Employee issue ages 18-67 Employee Actively at Work Full-time, benefit eligible employees working at least 20 hours per week Spouse issue ages 18-67; Ineligible if employee is denied. Child issue ages 0-25; Ineligible if employee is denied.
Product restrictions	If applying for the disability rider, the benefit will be reduced to a combined maximum of 60 percent of income when the applicant is applying for or has another disability-based benefit benefit in force with Kanawha Insurance Company or another company. Local, state, or federal disability benefits are considered to be other in force coverage when determining the maximum issue amount of accident disability benefits available when applying for the Accident Total Disability rider.

Policy: 60830 9/03
Underwritten by Kanawha Insurance Company

Humana Accident rates

HUMANA. Specialty Benefits

Kentucky

Pepsi Cola Bottling Co
5678112-01-008

Humana Accident rates

Displaying weekly payroll deductions based on monthly premium calculation including $1,500.00 Bone Fracture and Dislocation.

Benefit:	Level One Benefit			
Age	**Employee**	**Employee & Spouse**	**Employee & Children**	**Family**
18-50	$2.77	$5.54	$6.35	$9.12
51-67	$3.21	$6.42	$6.79	$10.00

Benefit:	Level Two Benefit			
Age	**Employee**	**Employee & Spouse**	**Employee & Children**	**Family**
18-50	$3.34	$6.67	$7.70	$11.04
51-67	$3.78	$7.55	$8.14	$11.91

Benefit:	Level Three Benefit			
Age	**Employee**	**Employee & Spouse**	**Employee & Children**	**Family**
18-50	$3.84	$7.67	$9.21	$13.04
51-67	$4.27	$8.54	$9.65	$13.92

Benefit:	Level Four Benefit			
Age	**Employee**	**Employee & Spouse**	**Employee & Children**	**Family**
18-50	$4.27	$8.54	$10.39	$14.66
51-67	$4.71	$9.42	$10.83	$15.54

The proposed rates are for an effective date no later than July 1, 2015.

Humana Critical Illness and Cancer

HUMANA. Specialty Benefits

Kentucky

Pepsi Cola Bottling Co

Consider coverage that helps protect you, your family, and your assets in the event of a critical illness. It offers specialized benefits to supplement other health insurance when you and your family may be most vulnerable: during the working years. Benefit payments can assist in covering a variety of expenses associated with a critical illness: out-of-pocket medical care costs, home healthcare, travel to and from treatment facilities, rehabilitation, and other expenses.

Coverage type

Voluntary Critical Illness insurance is a group policy form that includes coverage for heart/stroke, cancer, and other critical illnesses.

Benefit amount

Benefit amounts are available at various levels. You can choose:

- ❑ $5,000 to $50,000 for employees

You can also add coverage for your dependents:

- ❑ Spouse: $2,500 to $25,000. Spouse coverage benefit is equal to exactly half of the employee's coverage
- ❑ Child: $2,500 to $5,000 for each eligible child

Coverage for vascular conditions

Percent of benefit amount paid at initial diagnosis:

› Heart attack	100%
› Transplant as a result of heart failure	100%
› Stroke	100%
› Coronary artery bypass surgery as a result of coronary artery disease	25%

Coverage for cancer conditions

30 day waiting period

Percent of benefit amount paid at initial diagnosis:

› First diagnosis of internal cancer or malignant melanoma	100%
› Carcinoma in situ	25%

Coverage for other critical illnesses

Percent of benefit amount paid at initial diagnosis:

› Transplant, other than heart	100%
› End-stage renal failure	100%
› Loss of sight, speech, or hearing	100%
› Coma	100%
› Severe burns	100%
› Permanent paralysis due to an accident	100%
› Occupational HIV	100%

Additional included benefits

Waiver of premium for disability: This waives an employee's premium if he or she becomes totally disabled for at least 180 days after the effective date of coverage. For employees ages 18-55.

- ❑ **Benefit recurrence:** This provides an additional benefit for the same condition if a covered participant is treatment-free for at least 12 months.

- ❑ **Health screening:** Benefit pays per calendar year for covered health screenings. There are 18 covered tests including mammograms, colonoscopies, and stress tests.There is a 90-day waiting period.
  - > Indemnity based and payable once per calendar year per insured
  - > Employer selects this optional benefit and the benefit amount; Employee may decline the benefit if he/she chooses
  - > Coverage is same for all insureds on the certificate
  - ❑ $150

Underwritten by Kanawha Insurance Company, a Humana company.

This is not a complete disclosure of plan qualifications and limitations. Please access our website to obtain a completed list for the Workplace Voluntary Benefit products at **Disclosure.Humana.com**. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made.

Policy: 8011
Underwritten by Kanawha Insurance Company

1-800-327-9728 • HumanaVoluntaryBenefits.com

Humana Critical Illness and Cancer rates

HUMANA. Specialty Benefits

Kentucky

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5678112-01-008

Employee rates

Displaying weekly payroll deductions based on monthly premium calculation including Benefit Recurrence and $150 Health Screening Benefit.

Age	Employee NTU			Employee TU		
Benefit	**$5,000**	**$10,000**	**$20,000**	**$5,000**	**$10,000**	**$20,000**
18-29	$1.78	$2.36	$3.54	$2.09	$2.99	$4.79
30-39	$2.32	$3.45	$5.71	$3.07	$4.95	$8.71
40-49	$3.06	$4.93	$8.66	$4.45	$7.72	$14.25
50-55	$4.16	$7.14	$13.10	$6.51	$11.83	$22.46
56-59	$4.16	$7.14	$13.10	$6.51	$11.83	$22.46
60-64	$4.95	$8.71	$16.23	$8.00	$14.80	$28.42
65-69	$5.28	$9.38	$17.57	$8.18	$15.17	$29.16

Spouse rates

Monthly premiums with weekly deductions including Benefit Recurrence and $150 Health Screening Benefit.

Age	Spouse NTU			Spouse TU		
Benefit	**$2,500**	**$5,000**	**$10,000**	**$2,500**	**$5,000**	**$10,000**
18-29	$1.02	$1.34	$1.99	$1.20	$1.69	$2.68
30-39	$1.32	$1.93	$3.17	$1.73	$2.76	$4.83
40-49	$1.72	$2.75	$4.81	$2.49	$4.29	$7.87
50-55	$2.33	$3.96	$7.23	$3.62	$6.54	$12.37
56-59	$2.33	$3.96	$7.23	$3.62	$6.54	$12.37
60-64	$2.77	$4.84	$8.98	$4.44	$8.19	$15.67
65-69	$2.95	$5.21	$9.72	$4.55	$8.39	$16.09

NTU: Non-tobacco user; TU; Tobacco user

Children rates

Displaying weekly payroll deductions based on monthly premium calculation including Benefit Recurrence and $150 Health Screening Benefit.

Age	Children	
Benefit	**$2,500**	**$5,000**
0-24	$0.66	$0.96

Preventive services guide

Humana makes it easier than ever to get the preventive services you need to maintain your overall health. As part of healthcare reform — and depending on your Humana health plan — a range of preventive services will be available to you at no cost.

The services listed here will be covered **100 percent** when they're provided for preventive care. This means no copayments, coinsurance or deductible when services are performed by providers in the Humana network.

Note: You may need to pay all or part of the costs when services are completed to diagnose, monitor or treat an illness or injury, not as preventive care.

Remember, preventive care keeps you healthy, prevents illness, and detects diseases in the early stages when they're easier to treat.

Adult preventive services

Preventive office visits are covered, as well as the screenings, immunizations and counseling listed below.

Screenings	
Abdominal aortic aneurysm	One time screening for men of specified ages who have ever smoked
Alcohol misuse	Screening and counseling for all adults
Blood pressure	Screening for high blood pressure for all adults
Cholesterol	Screenings for adults certain ages or at higher risk[1]
Colorectal cancer	Screening for adults at 50 – 75
Depression	Screening for adults
Hepatitis B	Screening for all adults at higher risk[1]
Hepatitis C	Screening for adults at higher risk[1] or one-time screenings for adults born 1945 – 1965
HIV	Screening for all adults at higher risk[1]
Lung cancer	Annual screenings for adults all specified ages who smoke or have quit within the past 15 years
Obesity	Screening for all adults
Syphilis	Screening for all adults at higher risk[1]
Tobacco use	Screening for all adults and cessation interventions for tobacco users
Medications and supplements (covered with a doctor's prescription)	
Aspirin	Use of aspirin to prevent cardiovascular disease for women and men at specified ages
Smoking cessation	Over-the-counter and prescription smoking cessation medications for members 18 years and older
Vitamin D	Supplementation to prevent falls in community dwelling adults age 65 and older at increased risk for falls
Colonoscopy preparation	Bowel preparation medications for adults age 50 – 75
Other	
Exercise or physical therapy	Exercise or physical therapy for adults age 65 or older at increased risk for falls. Refer to your Certificate of Coverage for details about all the covered services and benefits levels.

Immunizations (vaccines for adults — doses, recommended ages, and recommended populations vary)
Hepatitis A
Hepatitis B
Herpes zoster
Human papillomavirus (HPV)
Influenza
Measles, mumps, rubella
Meningococcal
Pneumococcal
Tetanus, diphtheria, pertussis
Varicella
Counseling
Healthy diet and physical activity Counseling to prevent cardiovascular disease for adults who have cardiovascular risk factors or higher risk for chronic disease[1]
Obesity Referral to intensive, multicomponent behavioral interventions for patients with a body mass index (BMI) of 30 kg/m or higher
Sexually transmitted infection (STI) Prevention counseling for adults at higher risk[1]

[1]For more information on the definition of "higher risk" and age recommendations, please go to the US Preventive Guidelines at: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.Humana

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Women preventive services (includes pregnant women)

Preventive office visits are covered, as well as the screenings and counseling listed below.

Screenings	
Anemia	Screening on a routine basis for pregnant women
Bacteriuria	Urinary tract or other infection screening for pregnant women
BRCA	Screenings for women at higher risk[1]
Breast cancer mammography	Screenings every 1 – 2 years for women over 40 or over
Cervical cancer	Screening for women with a cervix, regardless of sexual history and at specified ages and intervals[3]
Chlamydia infection	Screening for younger women and other women at higher risk[1]
Gestational diabetes	Screenings for women after 24 weeks of gestation
Gonorrhea	Screening for all women at higher risk[1]
Hepatitis B	Screening for younger women and other women at higher risk[1]
HIV	Screenings for pregnant women
HPV-DNA test	High risk testing every 3 years for women with normal cytology results who are age 30 or older[1]
Osteoporosis	Screening for women age 65 and over and women at higher risk[1]
Rh incompatibility	Screening for all pregnant women during their first prenatal visit and at 24 – 28 weeks gestation
Syphilis	Screening for all pregnant women or other women at higher risk
Tobacco use	Screening and interventions for all women, and expanded counseling for pregnant tobacco users
Medications and supplements (covered with a doctor's prescription)	
Breast cancer preventive medications	For women at increased risk for breast cancer
Bacteriuria	FDA approved contraceptives for women with reproductive capacity to prevent pregnancy
Prenatal vitamins/folic acid	For women who may become pregnant or are capable of pregnancy

Counseling
Genetic counseling for women who have tested positive for BRCA
Breast cancer chemoprevention Counseling for women at increased risk for breast cancer
Domestic and interpersonal violence Screenings and referral for intervention services
Tobacco use counseling for pregnant women

Other services
Aspirin to prevent preeclampsia Low dose aspirin after 12 weeks of gestation in women who are at high risk[1]
Breast feeding[2] Equipment and counseling to promote breast feeding during pregnancy and in the postpartum period
Contraceptive methods and counseling[2]

[1]For more information on the definition of "higher risk" and age recommendations, please go to the US Preventive Guidelines at: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.Humana

[2]On Aug. 1, 2011, the U.S. Department of Health and Humana Services released new guidelines regarding coverage of preventive health services for women. The new guidelines state that non-grandfathered insurance plans with plan years beginning on or after Aug. 1, 2012, must include these services without cost sharing.

[3]Women 21-65: with cytology (Pap test) every three years; women 30 – 65: wanting to lengthen the screening interval. We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan. For complete details, refer to your plan's Certificate of Coverage

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Child preventive services

Preventive office visits are covered, as well as the screenings, immunizations, counseling and supplements listed below.

Screenings	
Alcohol and drug use	Assessments for adolescents
Autism	Screening for children at 18 – 24 months
Behavioral	Assessments for children of all ages
Congenital hypothyroidism	Screening for newborns
Depression	Screening for adolescents
Developmental	Screening for children under age 3, and surveillance throughout childhood
Dyslipidemia	Screening for children at higher risk[1] of lipid disorders
Gonorrhea	Preventive medication for the eyes of all newborns
Hearing	Screening for all newborns
Height, weight and body mass index	Measurements for children of all ages
Hematocrit or Hemoglobin	Screening for children of all ages
Hepatitis B	Screening for adolescents at higher risk[1]
HIV	Screening for adolescents at higher risk[1]
Lead	Screening for children at risk of exposure
Medical history	For all children throughout development
Obesity	Screening for children age 6 or older
Oral health	Risk assessment for young children
Phenylketonuria (PKU)	Screening for phenylketonuria in newborns
Sexually transmitted infection	Screening for adolescents at higher risk[1]
Tuberculin	Testing for children at higher risk[1] of tuberculosis
Vision	Screening for all children between the ages 3 – 5 years old
Medications and supplements (covered with a doctor's prescription)	
Fluoride chemoprevention	Supplements starting at age 6 months for children without fluoride in their water sources
Fluoride varnish	Application by a primary care clinician to primary teeth starting at tooth eruption up to age 5
Gonorrhea	Preventive medicine for the eyes of all newborns
Iron	Supplements for children ages 6 – 12 months at risk for anemia

Immunizations (vaccines for children from birth to age 18, doses, ages and populations vary)
Diphtheria, tetanus, pertussis
Haemophilus influenzae type B
Hepatitis A
Hepatitis B
Human papillomavirus (HPV)
Inactivated poliovirus
Influenza
Measles, mumps, rubella
Meningococcal
Pneumococcal
Rotavirus
Varicella

Counseling
Obesity Referral to intensive behavioral interventions to promote improvements in weight status
Sexually transmitted infection (STI) Prevention counseling for adolescents at higher risk[1]
Skin cancer Brief counseling for young adults age 10 – 24 years old to minimize their exposure to ultra violet radiation
Tobacco use Education or brief counseling to prevent initiation of tobacco use in school aged children and adolescents

[1]For more information on the definition of "higher risk" and age recommendations, please go to the US Preventive Guidelines at: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.Humana

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What to know, before you get your medicine – prior authorization

Understanding your pharmacy benefits

You may take prescription medicines to stay healthy. You may take some medicines for a short time, like an antibiotic to treat an infection. You may take other medicines all the time to treat problems like high blood pressure. Either way, it's important to know if your medicines need prior authorization before you get your prescription.

What is pharmacy prior authorization?

Some medicines need to be approved in advance to be covered under your pharmacy. For these medicines to be covered, your doctor must get approval from Humana. When this happens, it's called pre-approval – or "prior authorization."

Why do some medicines need prior authorization?

We ask for prior authorization to make sure medicines won't interfere with other medicines you're taking or add unnecessary costs. Prior authorization helps keep you safe, which is very important if you're taking certain medicines.

Medicines requiring prior authorization are typically costly, are only approved for certain conditions and may require patient monitoring. For example, if you have diabetes, and your doctor wants you to try a new medicine, we may need to authorize this medicine before you fill the prescription.

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Continued on back.

How do I know if my medicine needs prior authorization?

Each time your doctor prescribes a new medicine, ask them if it needs prior authorization. You also can:

- Sign in to MyHumana, your personal, secure online account on **Humana.com**, and click "Drug Pricing" under "Plan Tools" at the bottom of the page
- Call Humana Customer Care at the number on the back of your Humana member ID card
- Visit **Humana.com/DrugList**

What should I do if my medicine needs prior authorization?

If your medicine needs prior authorization, your doctor must contact Humana Clinical Pharmacy Review (HCPR) at **1-800-555-2546** to ask for approval. HCPR is available Monday - Friday, 8 a.m. - 6 p.m., Eastern time. Your doctor also can use tools available on **Humana.com/Providers**. We will notify your doctor once the request has been processed.

What happens after my doctor asks for prior authorization?

A team of pharmacists will review your doctor's request and either approve or deny it.

If your doctor's request is approved, your pharmacy benefits will cover your medicine. You'll pay any applicable coinsurance or copayment amounts if you buy the medicine.

If your doctor's request is denied, your pharmacy benefits won't cover your medicine. You can still purchase the medicine but you'll pay the full cost. Or, you can ask your doctor if there's another medicine that's right for you. There may be other medicines covered by your benefits that will work just as well but don't need prior authorization.

How long will it take to get prior authorization for my medicine?

After your doctor gets us all of the information we need, the request will be approved or denied within five business days. We'll mail letters to you and to your doctor with our decision.

Please contact your doctor to discuss other options. Your doctor can ask for an exception to our decision by contacting Humana Clinical Pharmacy Review (HCPR) at **1-800-555-2546**, Monday - Friday, 8 a.m. - 6 p.m., Eastern time.

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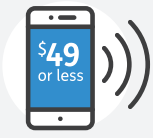
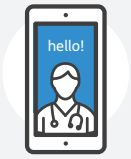
2. Enter your health insurance information; select Humana and enter your group ID and member ID

3. Enter a payment method



4. See a doctor within minutes



The doctor is always in

No waiting. No scheduling hassles. Less time off work. Doctor On Demand offers the opportunity to see a board-certified doctor in minutes, with video access from a mobile device or computer. It's easy.

Doctor On Demand may treat members, except children under the age of 2, for non-emergency health conditions. If needed, your physician may send a prescription to your pharmacy.

Issues that may be treated:

- Colds, flu and sore throat
- Upper respiratory infections
- Skin and eye problems
- Urinary tract infections

Telemedicine is not for emergencies such as chest pain, abdominal pain or shortness of breath.

Save you and your clients time and money!

Approximately 70% of ER visits are non-emergent and could be avoided.[1]

Four out of five smartphone users are interested in mobile health technologies that allow them to interact with a healthcare provider.[2]

Behavioral health visits are not covered. Limitations on healthcare and prescription services delivered by telemedicine and communication options vary by state. This material is provided for informational use only and should not be considered medical advice or used in place of consulting a licensed medical professional.

Telemedicine is not a substitute for emergency care and not intended to replace your primary care doctor or other providers in your network.

[1]"Avoidable Emergency Department Usage Analysis." Truven Health Analytics. (April 25, 2013)

[2]"Most smartphone users want mHealth interactions," FierceMobileHealthcare (June 29, 2014)

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