

KENTUCKY

**Humana CoverageFirst PPO 08
80/50 Plan**

		Plan pays for services at PARTICIPATING providers	Plan pays for services at NONPARTICIPATING providers
Up-front Benefit Allowance	<ul style="list-style-type: none"> Annual member <i>benefit</i> (Applies to medical services received from participating providers only. Preventive and pharmacy do not apply. Does not apply to member copayments.) 	\$500 per calendar year per member	Not applicable
Annual Deductible (per calendar year/ plan year; copayments do not apply)	<ul style="list-style-type: none"> Individual Family (1) 	<p>\$1,000</p> <p>Three times individual participating deductible</p>	<p>Three times individual participating deductible</p> <p>Three times family participating deductible</p>
Preventive Care (does not reduce the benefit allowance)	<ul style="list-style-type: none"> Annual routine adult physical exam (18 years and above) (2) Routine child care (up to age 18) Routine immunizations (up to age 18) Routine mammography and Pap smears Routine outpatient laboratory tests/X-rays Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy) 	<p>100% after office visit copayment</p> <p>100%</p>	<p>50% after deductible</p> <p>50% after deductible</p>
Physician Services (2)	<ul style="list-style-type: none"> Office visits (excludes diagnostic lab and X-ray) Prenatal benefit (office visit copayment applies to first visit only) Allergy testing (covered as part of office visit) Physician visits to emergency room (3) Diagnostic tests, lab and X-rays (when done in office by physician) Allergy serum Inpatient services Outpatient services Allergy injections and nonroutine injections other than allergy 	<p>100% after \$25 primary care physician/\$40 specialist copayment per visit</p> <p>100%</p> <p>100%</p> <p>80% after deductible</p> <p>100% after \$5 copayment per visit</p>	<p>50% after deductible</p> <p>100%</p> <p>50% after deductible</p> <p>50% after deductible</p>
Hospital Services	<ul style="list-style-type: none"> Inpatient care (semiprivate room and board, nursing care, ICU) Outpatient surgery Outpatient nonsurgical care Emergency room visit (copayment is waived if admitted) (3) 	<p>100% after \$100 copayment per day five days</p> <p>100% after \$100 copayment per visit</p> <p>80% after deductible</p> <p>100% after \$150 copayment per visit</p>	<p>50% after deductible</p> <p>50% after deductible</p> <p>50% after deductible</p> <p>100% after \$150 copayment per visit</p>
Prescription Drugs	<ul style="list-style-type: none"> Retail (30-day supply) Mail order (90-day supply) 	<p>100% after: Level One – \$10 copayment Level Two – \$25 copayment Level Three – \$50 copayment Level Four – 25% copayment (up to \$2,500 maximum out-of-pocket per calendar year)</p> <p>100% after two times the applicable copayment</p>	<p>Not covered</p> <p>Not covered</p>
Other Medical Services (4)	<ul style="list-style-type: none"> Skilled nursing facility (up to 60 days per calendar year) Home health care (up to 100 visits per calendar year) Durable medical equipment (unlimited) Physical, occupational, cognitive, speech and audiology therapy (unlimited) 	80% after deductible	50% after deductible

Humana CoverageFirst PPO 08 80/50 Plan

Plan pays for services at
PARTICIPATING providers

Plan pays for services at
NONPARTICIPATING providers

Other Medical Services (4) (continued)

- Ambulance (3)
- Chiropractic (up to 20 visits per calendar year)
- Transplant services

80% after deductible

Same as primary care physician copayment

Same as any other covered condition when services are received from a Humana Transplant Network provider. (when services are received from a Humana Transplant Network Provider)

80% after participating deductible

50% after deductible

Same as any other covered condition (covered expenses are limited to a maximum benefit of \$35,000 per transplant)

Behavioral Health (mental health and substance abuse services)

- Inpatient services
- Outpatient therapy sessions

Same as any other covered condition

Same as any other covered condition

Maximum Out-Of-Pocket Expense Limit

(per calendar year; excludes deductibles and copayments)

- Individual
- Family

\$2,000

Three times individual participating maximum out-of-pocket

Three times individual participating maximum out-of-pocket

Three times family participating maximum out-of-pocket

Lifetime Maximum Benefit

\$5,000,000
(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.

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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) You are not required to meet individual deductibles once the family deductible has been met.
- (2) Copayments for visits to primary care physicians, as defined in the plan, are generally lower than for visits to specialists. The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician or internist.

(3) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.

(4) Visit and day limits are combined for participating and nonparticipating providers.

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 benefit 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 Pre-existing condition exclusion information is applicable to all PPO and Classic products. If you are considering enrollment in an HMO or POS plan, please refer to your plan summary to determine if the plan contains a pre-existing condition exclusion.

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 12 months (18 months if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health

coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Humana Enrollment at 2432 Fortune Drive, Lexington, KY 40509 or call 1-800-872-7207.

HUMANA[®]
Guidance when you need it most

Humana Medical Plan Federal Mental Health Parity Addendum

This addendum amends the Mental Health and Substance Abuse sections of your benefit summary in accordance with provisions of the national Emergency Economic Stabilization Act of 2008, HR 1424.

The law is effective October 3, 2009 and applies to new or renewing groups with 51 or more total employees with an effective date of 11/01/09 or after.

Please refer to your updated Benefit Plan Document, also known as Certificate, for specific mental health benefits of your plan.

Mental Health Benefits

- The law defines mental health benefits as; “benefits with respect to services for mental health conditions as defined under the terms of the plan and in accordance with applicable Federal and State law.”
- Group health plans are permitted to define mental health conditions, taking into account any applicable state or federal law such as those mandating coverage for autism, serious mental illness or biologically based mental illness.
- Existing state mental health laws that prevent the application of the new federal requirements are preempted and no longer apply. State laws that do not prevent the application of the federal requirements are not preempted and continue to apply as they did before.

Group health plans must ensure the following:

Financial requirements for mental health and substance use disorder:

(i.e., deductibles, copayments, coinsurance, out of pocket expenses, but not including annual and lifetime limits)

- Cannot be more restrictive than the predominant financial requirements applied to substantially all medical/ surgical benefits;
- No separate cost sharing requirements applicable only to mental health and substance use disorder benefits.

Treatment limitations for mental health and substance use disorder:

(i.e., frequency, days of coverage, number of visits, duration of treatment, etc.)

- Cannot be more restrictive than the predominant treatment limitations applied to substantially all medical/ surgical benefits;
- No separate treatment limitations that apply only to mental health and substance use disorder benefits.



Humana Plans are offered by the Family of Insurance and Health Plan Companies including Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc. - A Health Maintenance Organization or insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Emphesys Insurance Company, or Humana Insurance of Puerto Rico, Inc. License # 00187-0009 or administered by Humana Insurance Company or Humana Health Plan, Inc.

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

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.

Anexo de la Ley Federal de Paridad de Salud Mental del plan médico de Humana

Este anexo enmienda las secciones sobre la Salud Mental y el Abuso de Sustancias de su resumen de beneficios de conformidad con las disposiciones de la Ley de Estabilización Económica de Emergencia nacional (Emergency Economic Stabilization Act) de 2008, HR 1424.

La ley entra en vigencia el 3 de octubre de 2009 y se aplica a grupos nuevos o renovados que cuentan con un total de 51 empleados o más con fecha de entrada en vigencia del 1o. de noviembre de 2009 en adelante.

Consulte el Documento de su plan de beneficios actualizado, conocido también como Certificado, para conocer los beneficios de salud mental específicos de su plan.

Beneficios de salud mental

- La ley define a los beneficios de salud mental como “beneficios en relación a servicios para afecciones mentales según se definen en los términos del plan y de conformidad con las leyes federales y estatales aplicables”.
- Los planes colectivos de salud pueden definir las afecciones mentales, teniendo en cuenta cualquier ley federal o estatal aplicable, como es el caso de aquellas que establecen la cobertura obligatoria para el autismo, la enfermedad mental grave o la enfermedad mental con base biológica.
- Las leyes estatales sobre salud mental existentes que evitan la aplicación de nuevos requisitos federales fueron reemplazadas y ya no se aplican. Las leyes estatales que no evitan la aplicación de requisitos federales no serán reemplazadas y continúan aplicándose como se hacía hasta el momento.

Los planes colectivos de salud deberán asegurar lo siguiente:

Requisitos financieros para afecciones mentales y de abuso de sustancias:

(es decir: deducibles, copagos, coaseguro, gastos de desembolso personal, pero sin incluir límites anuales y de por vida)

- No pueden ser más restrictivos que los requisitos financieros predominantes que se aplican a casi todos los beneficios médicos/quirúrgicos;
- Sin requisitos de distribución de costos por separado que se apliquen únicamente a los beneficios de afecciones mentales y de abuso de sustancias.

Limitaciones al tratamiento para afecciones mentales y de abuso de sustancias:

(es decir: frecuencia, días de cobertura, cantidad de visitas, duración del tratamiento, etc.)

- No pueden ser más restrictivas que las limitaciones al tratamiento predominantes que se aplican a casi todos los beneficios médicos/quirúrgicos;
- Sin limitaciones al tratamiento por separado que se apliquen únicamente a beneficios de afecciones mentales y de abuso de sustancias.



Los planes de Humana se ofrecen a través de la Family of Insurance and Health Plan Companies incluyendo a Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. No. de licencia: 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc., una Organización para el Mantenimiento de la Salud (HMO) o asegurados por Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Emphesys Insurance Company, o Humana Insurance of Puerto Rico, Inc. No. de licencia: 00187-0009 o administrado por Humana Insurance Company o Humana Health Plan, Inc.

En Arizona: Ofrecido por Humana Health Plan, o asegurado por Emphesys Insurance Company, o asegurado o administrado por Humana Insurance Company

Los enunciados que este documento contenga en otro idioma que no sea el inglés, podrían no manifestar rigurosamente el significado de la póliza original ya que existe la posibilidad de diferencias lingüísticas. En caso de haber alguna discrepancia, la versión en inglés asumirá la validez exclusiva.

KENTUCKY
HumanaPPO 08
80/50 Plan

		Plan pays for services at PARTICIPATING providers	Plan pays for services at NONPARTICIPATING providers
Preventive Care (1)	<ul style="list-style-type: none"> Routine immunizations (to age 18) Routine Pap smear Annual routine mammogram Routine lab test and X-ray Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy) 	100%	50% after deductible
	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Office visits Diagnostic, lab and X-rays (copayment does not apply) Allergy testing (copayment does not apply) 	100% after \$25 primary care physician/\$40 specialist copayment per visit	50% after deductible
	<ul style="list-style-type: none"> Inpatient services Outpatient services Office surgery Emergency room physician visits (2) 	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> Allergy injections and nonroutine injections other than allergy 	100% after \$5 copayment per visit	50% after deductible
Facility Services	<ul style="list-style-type: none"> Inpatient hospital care 	100% after \$150 copayment per day for five days	50% after deductible
	<ul style="list-style-type: none"> Outpatient surgery 	100% after \$100 copayment per visit	50% after deductible
	<ul style="list-style-type: none"> Outpatient nonsurgical care Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) 	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> Hospital emergency services (emergency room copayment waived if admitted) (2) 	80% after \$150 copayment per visit	50% after \$150 copayment per visit
Prescription Drugs (includes oral contraceptives)	<ul style="list-style-type: none"> Member pharmacy (30-day supply) 	100% after: Level One – \$15 copayment Level Two – \$30 copayment Level Three – \$50 copayment Level Four – 25% copayment (up to \$2,500 maximum out-of-pocket per calendar year)	Not covered
	<ul style="list-style-type: none"> Mail order (90-day supply) 	100% after two times the applicable copayment	Not covered
Other Medical Services (3)	<ul style="list-style-type: none"> Skilled nursing facility (up to 60 days per calendar year) Home health (up to 100 visits per calendar year) Durable medical equipment (unlimited) 	80% after deductible	50% after deductible
	<ul style="list-style-type: none"> Physical, occupational, cognitive, speech and audiology therapy (up to combined limit for all therapy services up to 30 visits per calendar year) 	100% after \$25 copayment per visit	50% after \$25 copayment
	<ul style="list-style-type: none"> Urgent care facility 	100% after \$35 copayment per visit	50% after \$75 copayment
	<ul style="list-style-type: none"> Chiropractic services (up to 12 visits per calendar year) 	100% after primary care physician copayment per visit	50% after deductible
	<ul style="list-style-type: none"> Ambulance (2) 	100%	100%
	<ul style="list-style-type: none"> Transplant services 	Same as any other covered condition when services are received from a Humana Transplant Network provider (when services are received from a Humana Transplant Network Provider)	Same as any other covered condition (covered expenses are limited to a maximum benefit of \$35,000 per transplant)

**HumanaPPO 08
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 <i>(per calendar year; copayments do not apply)</i>	<ul style="list-style-type: none"> • Individual • Family (4) 	\$500 Two times individual participating deductible	Three times individual participating deductible Three times family participating deductible
Out-of-Pocket Maximum <i>(per calendar year; deductibles and copayments do apply)</i>	<ul style="list-style-type: none"> • Individual • Family 	\$2,500 Two times individual participating out-of-pocket maximum	Three times individual participating out-of-pocket maximum Three times family participating out-of-pocket maximum
Lifetime Maximum Benefit	\$5,000,000 <i>(participating and nonparticipating combined)</i>		
Behavioral Health <i>(mental health and substance abuse)</i>	<ul style="list-style-type: none"> • Inpatient services • Outpatient therapy sessions 	Same as any other covered condition	Same as any other covered condition

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.

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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.

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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.

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/enrollmentcenter/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.

The Pre-existing condition exclusion information is applicable to all PPO and Classic products. If you are considering enrollment in an HMO or POS plan, please refer to your plan summary to determine if the plan contains a pre-existing condition exclusion.

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 12 months (18 months if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health

coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

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Humana Medical Plan Federal Mental Health Parity Addendum

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The law is effective October 3, 2009 and applies to new or renewing groups with 51 or more total employees with an effective date of 11/01/09 or after.

Please refer to your updated Benefit Plan Document, also known as Certificate, for specific mental health benefits of your plan.

Mental Health Benefits

- The law defines mental health benefits as; “benefits with respect to services for mental health conditions as defined under the terms of the plan and in accordance with applicable Federal and State law.”
- Group health plans are permitted to define mental health conditions, taking into account any applicable state or federal law such as those mandating coverage for autism, serious mental illness or biologically based mental illness.
- Existing state mental health laws that prevent the application of the new federal requirements are preempted and no longer apply. State laws that do not prevent the application of the federal requirements are not preempted and continue to apply as they did before.

Group health plans must ensure the following:

Financial requirements for mental health and substance use disorder:

(i.e., deductibles, copayments, coinsurance, out of pocket expenses, but not including annual and lifetime limits)

- Cannot be more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits;
- No separate cost sharing requirements applicable only to mental health and substance use disorder benefits.

Treatment limitations for mental health and substance use disorder:

(i.e., frequency, days of coverage, number of visits, duration of treatment, etc.)

- Cannot be more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits;
- No separate treatment limitations that apply only to mental health and substance use disorder benefits.



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Anexo de la Ley Federal de Paridad de Salud Mental del plan médico de Humana

Este anexo enmienda las secciones sobre la Salud Mental y el Abuso de Sustancias de su resumen de beneficios de conformidad con las disposiciones de la Ley de Estabilización Económica de Emergencia nacional (Emergency Economic Stabilization Act) de 2008, HR 1424.

La ley entra en vigencia el 3 de octubre de 2009 y se aplica a grupos nuevos o renovados que cuentan con un total de 51 empleados o más con fecha de entrada en vigencia del 1o. de noviembre de 2009 en adelante.

Consulte el Documento de su plan de beneficios actualizado, conocido también como Certificado, para conocer los beneficios de salud mental específicos de su plan.

Beneficios de salud mental

- La ley define a los beneficios de salud mental como “beneficios en relación a servicios para afecciones mentales según se definen en los términos del plan y de conformidad con las leyes federales y estatales aplicables”.
- Los planes colectivos de salud pueden definir las afecciones mentales, teniendo en cuenta cualquier ley federal o estatal aplicable, como es el caso de aquellas que establecen la cobertura obligatoria para el autismo, la enfermedad mental grave o la enfermedad mental con base biológica.
- Las leyes estatales sobre salud mental existentes que evitan la aplicación de nuevos requisitos federales fueron reemplazadas y ya no se aplican. Las leyes estatales que no evitan la aplicación de requisitos federales no serán reemplazadas y continúan aplicándose como se hacía hasta el momento.

Los planes colectivos de salud deberán asegurar lo siguiente:

Requisitos financieros para afecciones mentales y de abuso de sustancias:

(es decir: deducibles, copagos, coaseguro, gastos de desembolso personal, pero sin incluir límites anuales y de por vida)

- No pueden ser más restrictivos que los requisitos financieros predominantes que se aplican a casi todos los beneficios médicos/quirúrgicos;
- Sin requisitos de distribución de costos por separado que se apliquen únicamente a los beneficios de afecciones mentales y de abuso de sustancias.

Limitaciones al tratamiento para afecciones mentales y de abuso de sustancias:

(es decir: frecuencia, días de cobertura, cantidad de visitas, duración del tratamiento, etc.)

- No pueden ser más restrictivas que las limitaciones al tratamiento predominantes que se aplican a casi todos los beneficios médicos/quirúrgicos;
- Sin limitaciones al tratamiento por separado que se apliquen únicamente a beneficios de afecciones mentales y de abuso de sustancias.



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