Your 2015 Health Benefits for SmartSuite

Hamilton County

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

A guide to your healthcare coverage

what's *inside*

Throughout this guide, you'll find lots of information to help you choose and use your plan:

Step 1 – know what you need
Before you choose your benefits, take a few minutes to find out what kind of healthcare coverage you want and need. Thinking about how you'll use your plan is the first step in choosing with confidence.

Step 2 – explore your options
After finding out about your needs, it's time to see what fits them. The plan information in this section explains what's available to you, why you might want it, and how it works.

Step 3 – choose and use your plan
Now you're ready to roll – or enroll! This section describes the resources available to help you choose a health benefits plan. It also gives you some tips on using the plan you select.

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Step 1
Know what you need

Before you choose your benefits, take a few minutes to find out what kind of healthcare coverage you want and need. Thinking about how you'll use your plan is the first step in choosing with confidence.

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Step 1
Know what you need

Are you looking for something practical and economical or something sporty with lots of extras?

One size doesn't fit all. That's why you have so many choices at the car lot and the grocery store. It's also why your employer is giving you a choice of health benefits, so you can "shop" for one that meets your unique requirements.

Sorting through the options takes some effort, though. Before you bought your last car, it's likely you spent hours – maybe days – thinking about:

- What you want – red or black, domestic or import?
- What you need – SUV or sports car, safety features or speed?
- How much you're willing to spend – economy car or lots of features?

When you choose a health plan, it may take an hour or more to find the right balance of features and cost – but it's worth the time. After all, your health plan choice affects you, your family, and your cash flow for a long time.

What will provide the right amount of coverage for you and your family?

When choosing a health benefits plan, knowing what you spent in the past makes it easier. The planner on the next page can help.

Gather your medical expense records – your calendar, checkbook, receipts, and Explanation of Benefits (EOB) summaries – to see the services you received and how much you paid for copayments, deductibles, and coinsurance.

What options do you need to look at?

To weigh your options, you have to know what they are. Here are some terms you may see as you compare plans.

- **Copayment** – The amount you pay when you receive medical care or a prescription drug. It varies depending on your plan and the services you receive. Copayments do not apply to your deductible, but do apply to your out-of-pocket maximum.
- **Deductible** – The amount you pay toward certain medical expenses before your plan starts paying its share of the costs. Except for copayments, most of your expenses accumulate toward the deductible.
- **Coinsurance** – A set percentage of the total cost you must pay for your medical or dental services or prescription drugs. For example, if your coinsurance is 70/30, once you meet your deductible, your plan pays 70 percent and you pay 30 percent.
- **Out-of-pocket maximum** – The limit, or ceiling, on your costs for medical and pharmacy care within the plan year. As you use services, much of what you spend counts toward your maximum. Once you reach the limit, your plan pays 100 percent of covered services.

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Step 1
Know what you need

Do you put lots of miles on it or does it sit in the garage?

This diary gives you a general idea of how much you spent on healthcare during the previous plan year. In general, you have two kinds of costs:

1. Premiums stay the same whether you use healthcare or not
2. Out-of-pocket costs vary depending on your healthcare usage later

With many types of plans, if your premium is higher, you have lower out-of-pocket costs when you receive care and vice versa.

1. How much did you pay in premiums?	
Total annual payroll deduction for your premium (Amount each paycheck x pay periods per year)	$

2. How much did you and your family pay in out-of-pocket costs like copayments, deductible, and coinsurance?

Service	Your cost	x	Number of visits	=	Total
Primary care visit	$	x		=	
Specialist visit	$	x		=	
Urgent care	$	x		=	
Emergency room	$	x		=	
Hospital	$	x		=	
Deductible (enter amount you actually paid toward the deductible)					$
Coinsurance (enter the amount you actually paid)					$
Prescription drugs	Your cost	x	No. of times filled	=	Total
	$	x		=	$
	$	x		=	$
	$	x		=	$
	$	x		=	$
Vision, Dental, Hearing, Chiropractor, Etc.	Your cost	x	No. of times	=	Total
	$	x		=	$
	$	x		=	$
	$	x		=	$
	$	x		=	$
Grand total					$

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Step 1
Know what you need

Will your needs change?

When choosing a plan, also consider what you'll need in the future. This chart lists estimated charges for different types of office visits, as well as other services you might have during an office visit.* In addition to routine healthcare, think about whether you or anyone your plan covers is expecting something this year, like surgery or pregnancy.

Keep in mind

You'll pay a smaller share of your costs when you go to in-network providers – doctors, facilities, and other providers who offer discounted rates for Humana members. And if you go out-of-network:

- You may pay toward a separate deductible
- The provider may bill you for amounts not covered by your plan

Procedure	Average cost*
Office visits	
New patient (10 minutes)	$40
New patient (60 minutes)	$185
Established patient (10 minutes)	$40
Established patient (60 minutes)	$130
Doctor visits – Preventive care	
Initial comprehensive visit; new patient (infant under one year)	$110
Initial comprehensive visit; new patient (65 years and over)	$160
Periodic comprehensive visit; established patient (infant under one year)	$80
Periodic comprehensive visit; established patient (65 years and over)	$125
Mammography	
Computer-aided detection with physician explanation; diagnostic mammogram	$20
Diagnostic mammography, bilateral	$100
Computer-aided detection with physician explanation; screening mammogram	$20
Screening mammography, bilateral	$80
Ultrasound	
Ultrasound, first trimester	$140
Laboratory services	
Lipid panel	$30
Automated hemogram (blood work) with automated differential white blood cell count	$15
Automated hemogram	$10
Immunization	
Immunization fee; first injection	$20
Flu vaccine; 3-35 months old	$15
Flu vaccine; 3 years old and above	$15
Allergy testing	
Tests with allergenic extracts	$5

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*This is for illustration purposes only. The actual amount will vary depending on your geographical location and the type of plan you choose.

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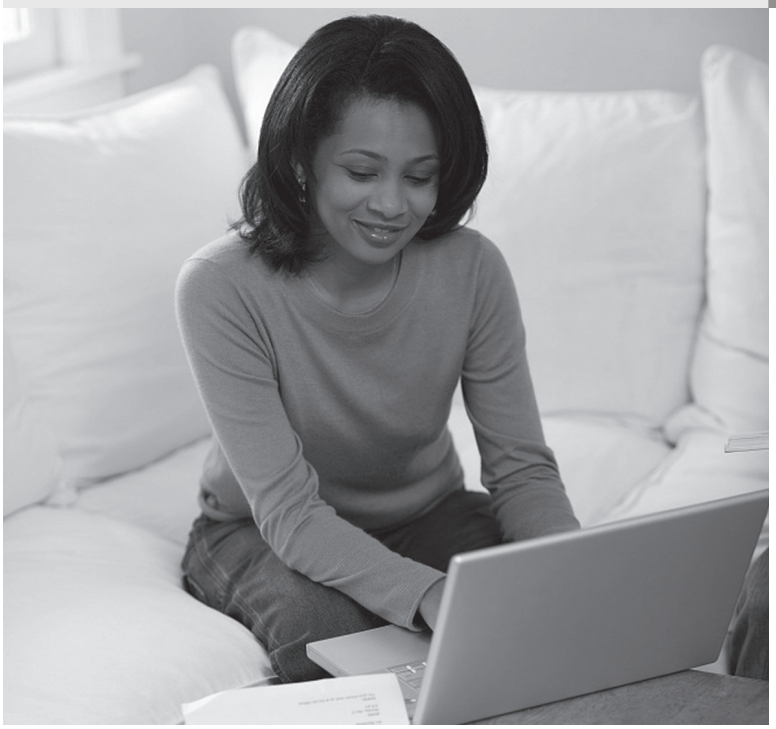
Step 2



explore your options

After finding out about your needs, it's time to see what fits them. The plan information in this section explains what's available to you, why you might want it, and how it works.

CoverageFirst®

How it works

What is CoverageFirst?

With CoverageFirst, you can see any provider without a referral – but your costs are usually lower when you use in-network providers. What makes CoverageFirst unique is the **$500-per-covered member** "benefit allowance" that covers many services from in-network providers before you start paying toward your deductible.

Here's how it works:

1. The plan pays the first $500 of eligible expenses from in-network providers. You just pay a copayment.
2. If you use the entire $500, you pay most additional expenses until you meet the annual deductible. The plan has a separate $500 allowance and a separate deductible for each family member; each person's costs also apply to a deductible for the entire family.

Why you might want CoverageFirst

CoverageFirst offers lower premiums and a "safety net" in case of a major illness or injury.

- **Your up-front costs are lower.** CoverageFirst premiums are generally lower than with other plan types.
- **You could have very low out-of-pocket costs.** Many health plan members spend less than $500 a year on medical care.* If you're in that group, the CoverageFirst allowance might cover all of your costs except your copayments.
- **Preventive care coverage.** Even if your $500 is gone, CoverageFirst covers your preventive care office visits. However, you would be responsible for special procedures billed separately, such as lab work.
- **The out-of-pocket maximum provides peace of mind.** If you have a serious illness or injury, your costs for covered services at in-network providers are capped.

Using your allowance

The entire $500 is available on the first day of the plan year. You can use the allowance for:

- Doctor's office visits
- Routine outpatient laboratory tests and X-rays
- Hospital services, including semiprivate room and board, emergency room services, and outpatient surgery
- Other services such as home healthcare, physical therapy, and hospice care

Your allowance isn't depleted when you fill a prescription or receive mental health services. Also, the allowance doesn't cover copayments or any services from out-of-network providers. Check the summary plan description for details about plan benefits, limitations, and exclusions.

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Example one — Lynn (single coverage)

Lynn chooses a CoverageFirst plan with:
- **$500 allowance**
- **$3,000 deductible**
- **100 percent coinsurance** (in-network)

Lynn goes to her primary care physician and finds out she needs some blood work.

• Doctor's office visit (Lynn pays a $25 copayment)	$50
• Outpatient lab (no copayment)	$400
How Lynn uses CoverageFirst	
Total cost of medical services	$450
Lynn's copayments	$25
CoverageFirst pays the remaining costs	**$425**

Summary

Lynn's medical expenses for the calendar year didn't exceed her $500 CoverageFirst allowance. The only medical expenses she paid were copayments totaling $25.

Example two — Greg (family coverage)

Greg chooses a CoverageFirst plan.
Each covered member has:
- **$500 allowance**
- **$2,500 deductible**
- **80 percent coinsurance** (in-network)
- **$3,000 out-of-pocket maximum** (does NOT include the deductible)

Greg is injured in a fall. He goes to the emergency room and spends two days in the hospital. Later, he has a follow-up visit with a specialist.

• Hospital care (Greg pays $500 in copayments)	$10,000
• One specialist visit (Greg pays $50 copayment)	$150
How Greg uses CoverageFirst	
Total cost of medical services	$10,150
Deduct Greg's total copayments	(-$550)
Remaining cost of medical services	$9,650
CoverageFirst pays $500 of remaining cost.	**$9,150**
Greg is now responsible for his deductible	(-$2,500)
Remaining cost of medical services	$6,650
Greg's plan pays 80 percent of remaining cost, leaving Greg to pay 20 percent— **$6,650 x 20% = $1,330**	

Summary

Greg's out-of-pocket maximum is $3,000. He has met $1,330 (his deductible did not apply to the out-of-pocket maximum). Greg must pay $1,670 more in medical costs until he reaches his out-of-pocket maximum. Then his plan will start paying 100 percent of the remaining medical costs for the rest of his plan year.

* These examples may not apply to all lines of business (PPO, POS, HMO)

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Step 3

choose and use your plan

Now you're ready to roll – or enroll! This section describes the resources available to help you choose a health benefits plan. It also gives you some tips on using the plan you select.

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NATIONAL POS COPAYMENT 90/60 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Preventive Care (1)		
• Routine immunizations (except for travel) • Routine Pap smear • Annual routine mammogram • Routine lab test and X-ray • Preventive endoscopy (includes proctosigmoidoscopy and sigmoidoscopy) • Colonoscopy • Routine adult physical exam (18 years and above) • Routine child exams (to age 18)	100%	60% after deductible
• Vision exam (refraction limited to one per 24 months)	100% after $45 copayment	60% after deductible
Physician Services (1)		
• Office visits • Diagnostic, lab and X-rays (copayment does not apply) • Allergy testing (copayment does not apply)	100% after $30 primary care physician/ $45 specialist copayment per visit	60% after deductible
• Inpatient services • Outpatient services (includes surgery) • Office surgery	90% after deductible	60% after deductible
• Emergency room physician visits (2)	100%	100%
• Allergy injections and nonroutine injections other than allergy	100% after $5 copayment per visit	60% after deductible

(1) The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician or internist

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

NATIONAL POS COPAYMENT 90/60 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS		PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS	
Facility Services				
• Inpatient hospital care • Outpatient surgery • Outpatient nonsurgical care (does not include advanced imaging) • Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)	90% after deductible		60% after deductible	
• Hospital emergency services (emergency room copayment waived if admitted) (2)	100% after $200 copayment per visit		100% after $200 copayment per visit	
Prescription Drugs (includes oral contraceptives)	Please see attached pharmacy benefit information, if applicable			
Other Medical Services (3)				
• Skilled nursing facility (subject to 60 day limit per calendar year) • Home health (unlimited) • Physical, occupational, cognitive, speech and hearing therapy (subject to combined limit for all therapy services up to 60 visits per calendar year) • Durable medical equipment (unlimited)	90% after deductible		60% after deductible	
• Urgent care facility	100% after $75 copayment per visit		60% after deductible	
• Chiropractic services (subject to 25 visits per calendar year)	100% after specialist copayment per visit		60% after deductible	
• Ambulance (2)	90% after deductible		90% after participating deductible	
• Transplant services	90% after deductible (when services are received from a Humana Transplant Network Provider)		60% after deductible (covered expenses are limited to a maximum benefit of $35,000 per transplant)	
Deductible and Out-of-Pocket Maximum Accumulation Methods	Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately			
Deductible (per calendar year; medical and pharmacy copayments do not apply)	Individual $500	Family (4) $1,000	Individual $1,500	Family (4) $3,000
Medical Coinsurance/Medical Copayments Maximum (per calendar year; medical copayments and coinsurance amounts apply; pharmacy copayments do not apply)	Individual $2,000	Family $4,000	Individual $6,000	Family $12,000
Plan Out-of-Pocket Maximum (per calendar year; deductible, coinsurance amounts, medical & pharmacy copayments apply)	Individual $6,350	Family $12,700	Individual Unlimited	Family Unlimited
Lifetime Maximum Benefit	Unlimited (participating and nonparticipating combined)			

(2) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Summary Plan Description.
(3) Visit and day limits are combined for participating and nonparticipating providers.
(4) You are not required to meet individual deductibles once the family deductible has been met

NATIONAL POS COPAYMENT 90/60 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Behavioral Health (mental health and substance abuse) (5)		
• Inpatient services	Same as inpatient hospital care	60% after deductible
• Outpatient therapy sessions	100% after $30 copayment	60% after deductible

(5) Biologically-based mental illness (BMI) is covered same as any other illness.

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Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

Payments - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Summary Plan Description.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Participating primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

To be covered, expenses must be medically necessary and specified as covered. Please see your Summary Plan Description for more information on medical necessity and other specific plan benefits

The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

For general questions about the plan, contact your benefits administrator.

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NATIONAL POS COVERAGEFIRST COINSURANCE 80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS		PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS	
Up-front Benefit Allowance				
• Annual member benefit (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	
Deductible and Out-of-Pocket Maximum Accumulation Methods	Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately			
Deductible (per calendar year; medical and pharmacy copayments do not apply)	Individual $1,000	Family $2,000	Individual $3,000	Family $6,000
Medical Coinsurance/Medical Copayments Maximum (per calendar year; medical copayments and coinsurance amounts apply; pharmacy copayments do not apply)	Individual $2,000	Family $4,000	Individual $6,000	Family $12,000
Plan Out-of-Pocket Maximum (per calendar year; deductible, coinsurance amounts, medical & pharmacy copayments apply)	Individual $6,350	Family $12,700	Individual Unlimited	Family Unlimited
Lifetime Maximum Benefit	Unlimited (participating and nonparticipating combined)			

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NATIONAL POS COVERAGEFIRST COINSURANCE 80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Preventive Care (Does not reduce the benefit allowance)		
• Annual routine adult physical exam (18 years and above) • Routine child care (up to age 18) • Routine immunizations (except for travel) • Routine mammography and Pap smears • Routine outpatient laboratory tests/ X-rays • Preventive endoscopy (includes proctosigmoidoscopy and sigmoidoscopy) • Colonoscopy	100%	50% after deductible
• Vision exam (refraction limited to one per 24 months)	100% after $35 copayment	50% after deductible
Physician Services (2)		
• 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)	100% after $20 primary care physician/ $35 specialist copayment per visit	50% after deductible
• Physician visits to emergency room (3)	100%	100%
• Diagnostic tests, lab and X-rays (when done in office by physician) • Allergy serum	100%	50% after deductible
• Inpatient services • Outpatient services	80% after deductible	50% after deductible
• Allergy injections and nonroutine injections other than allergy	100% after $5 copayment per visit	50% after deductible
Hospital Services		
• Inpatient care (semiprivate room and board, nursing care, ICU) • Outpatient surgery – facility • Outpatient nonsurgical care	80% after deductible	50% after deductible
• Emergency room visit (copayment is waived if admitted) (3)	100% after $200 copayment per visit	100% after $200 copayment per visit
Prescription Drugs	• Please see attached pharmacy benefit information, if applicable	
Other Medical Services		
• Skilled nursing facility (up to 60 days per calendar year) • Home health care (unlimited) • Durable medical equipment (unlimited) • Physical, occupational, cognitive, speech and hearing therapy (subject to combined limit for all therapy services up to 60 visits per calendar year)	80% after deductible	50% after deductible
• Ambulance (3)	80% after deductible	80% after participating deductible

NATIONAL POS COVERAGEFIRST COINSURANCE 80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Other Medical Services (continued)		
• Chiropractic (25 visits per calendar year)	Same as specialist copayment	50% after deductible
• Transplant services	80% after deductible (when services are received from a Humana Transplant Network Provider)	50% after participating deductible (covered expenses are limited to a maximum benefit of $35,000 per organ transplant)
Behavioral Health (mental/chemical/alcohol combined)		
• Inpatient services • Outpatient therapy sessions	Same as any other covered condition	Same as any other covered condition

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To be covered, expenses must be medically necessary and specified as covered. Please see your Summary Plan Description for more information on medical necessity and other specific plan benefits.

(1) 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 Summary Plan Description.

The amount of benefit provided depends upon the plan selected. Premiums will vary according to the selection made.

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NATIONAL POS COVERAGEFIRST COINSURANCE 100/70 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS		PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS	
Up-front Benefit Allowance				
• Annual member benefit (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	
Deductible and Out-of-Pocket Maximum Accumulation Methods	Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately			
Deductible (per calendar year; medical and pharmacy copayments do not apply)	Individual $2,500	Family $5,000	Individual $7,500	Family $15,000
Medical Coinsurance/Medical Copayments Maximum (per calendar year; medical copayments and coinsurance amounts apply; pharmacy copayments do not apply)	Individual $2,000	Family $4,000	Individual $6,000	Family $12,000
Plan Out-of-Pocket Maximum (per calendar year; deductible, coinsurance amounts, medical & pharmacy copayments apply)	Individual $6,350	Family $12,700	Individual Unlimited	Family Unlimited
Lifetime Maximum Benefit	Unlimited (participating and nonparticipating combined)			

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NATIONAL POS COVERAGEFIRST COINSURANCE 100/70 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Preventive Care (Does not reduce the benefit allowance)		
• Annual routine adult physical exam (18 years and above) • Routine child care (up to age 18) Routine immunizations (except for travel) • Routine mammography and Pap smears • Routine outpatient laboratory tests/ X-rays • Preventive endoscopy (includes proctosigmoidoscopy and sigmoidoscopy) • Colonoscopy	100%	70% after deductible
• Vision exam (refraction limited to one per 24 months)	100% after $40 copayment	70% after deductible
Physician Services (2)		
• 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)	100% after $25 primary care physician/ $40 specialist copayment per visit	70% after deductible
• Physician visits to emergency room (3)	100%	100%
• Diagnostic tests, lab and X-rays (when done in office by physician) • Allergy serum	100%	70% after deductible
• Inpatient services • Outpatient services	100% after deductible	70% after deductible
• Allergy injections and nonroutine injections other than allergy	100% after $5 copayment per visit	70% after deductible
Hospital Services		
• Inpatient care (semiprivate room and board, nursing care, ICU) • Outpatient surgery – facility • Outpatient nonsurgical care	100% after deductible	70% after deductible
• Emergency room visit (copayment is waived if admitted) (3)	100% after $200 copayment per visit	100% after $200 copayment per visit
Prescription Drugs	• Please see attached pharmacy benefit information, if applicable	
Other Medical Services		
• Skilled nursing facility (up to 60 days per calendar year) • Home health care (unlimited) • Durable medical equipment (unlimited) • Physical, occupational, cognitive, speech and hearing therapy (subject to combined limit for all therapy services up to 60 visits per calendar year)	100% after deductible	70% after deductible
• Ambulance (3)	100% after deductible	100% after participating deductible
• Chiropractic (25 visits per calendar year)	Same as specialist copayment	70% after deductible

NATIONAL POS COVERAGEFIRST COINSURANCE 100/70 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Other Medical Services (continued)		
• Transplant services	100% after deductible (when services are received from a Humana Transplant Network Provider)	70% after participating deductible (covered expenses are limited to a maximum benefit of $35,000 per organ transplant)
Behavioral Health (mental/chemical/alcohol combined)		
• Inpatient services • Outpatient therapy sessions	Same as any other covered condition	Same as any other covered condition

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Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

Payments - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Summary Plan Description.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

To be covered, expenses must be medically necessary and specified as covered. Please see your Summary Plan Description for more information on medical necessity and other specific plan benefits.

(1) 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 Summary Plan Description.

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.

Administered by Humana Health Plan, Inc

Humana®

Humana.com

HumanaPOS Rx4

Hamilton County

Level One - $15, Level Two - $30, Level Three - $50, Level Four - 25%

How the Rx4 structure works

Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts. The levels are organized as follows:

- **Level One:** Lowest copayment for low cost generic and brand-name drugs.
- **Level Two:** Higher copayment for higher cost generic and brand-name drugs.
- **Level Three:** Higher copayment than Level Two for higher cost, brand-name drugs that may have generic or brand-name alternatives on Levels One or Two.
- **Level Four**: Highest copayment for high-technology drugs (certain brand-name drugs, and self-administered injectable medications).
- If you request a brand-name drug when a generic equivalent is available, you pay the applicable generic copayment, plus the cost difference between the brand-name and generic drugs. If your doctor indicates that a generic drug cannot be substituted by writing "Dispense as Written" on your prescription, you can only receive that specific drug, even if a generic equivalent is available. As a result, you will be charged the applicable brand-name copayment. In this case, you will not be responsible for the cost difference between the brand and generic. If you discover at the pharmacy that your doctor gave you a "Dispense as Written" prescription, you can ask the pharmacist to contact your doctor for approval of a generic equivalent.

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

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

Members can visit Humana's Website, **Humana.com**, to obtain information about their prescription drug and corresponding benefits and for possible lower cost alternatives, or they can call Humana's Customer Service with questions or to request a partial Humana Rx4 Drug List by mail.

Coverage at participating pharmacies

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

Drugs assigned to:	**Copayment per prescription or refill**
Level One:	$15
Level Two:	$30
Level Three:	$50
Level Four:	**25%** of the total required payment to the dispensing pharmacy per prescription or refill to a maximum of $250 per prescription

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

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

Nonparticipating pharmacy coverage*

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

- You pay 100 percent of the dispensing pharmacy's charges.
  - You file a claim form with Humana (address is on the back of ID card).
  - Claim is paid at 70 percent of the default rate, after it is first reduced by the applicable copayment.
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.

* In Georgia, the nonparticipating benefits are paid the same as the participating benefits, per state regulation.

Coverage specifics

Your coverage includes the following:

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

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

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

Mail-order and 90-day Retail

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

* See Specialty Drug Benefit flyer where applicable.

Definition of terms

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

Administered by Humana Insurance Company

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

Our health benefit plans have limitations and exclusions

Humana®

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Savings Center

One more reason to **choose** Humana

The Savings Center is a great place to find ways to lower the cost of staying healthy. Take advantage of these Humana member discounts as often as you like:

Vision discount programs

- **EyeMed – 1-866-392-6056** Discounts on routine exams, eyeglass frames and lenses – including a wide range of lens options – contact lenses, and laser correction.

To receive your EyeMed discount:

- Visit Physician Finder Plus on **Humana.com** to locate an EyeMed Vision provider near you
- Tell the EyeMed provider you're a Humana member with EyeMed Vision benefits
- Print the discount ID card – you'll find a link on the EyeMed, TruVision, and Alternative Medicine pages – or present your Humana medical or dental ID card to your EyeMed provider

Your EyeMed provider will apply the discount directly to your purchase.

- **TruVision – 1-877-580-2020** Traditional and custom LASIK to correct problems such as nearsightedness, farsightedness, and astigmatism, offered at more than 200 TruVision centers nationwide for less than $1,000 per eye.

Services include:

- Telephone screening
- Comprehensive eye exam
- LASIK procedure on an FDA-approved excimer laser
- Postoperative care
- Retreatment warranty

To schedule an exam, determine price, find a location in your area, or get more information, call a Customer Care specialist at **1-877-580-2020**.

Cut out this card and keep it in your wallet for handy reference.

Humana. Discount card

Subscriber name: _____

Subsciber ID: _____

ANSI/BIN#	610649
VISION:	EyeMed and TruVision
Alternative Medicine	HWHN

These discount programs are not part of your insurance.
Discounts are available only at participating providers.

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Complementary and Alternative Medicine (CAM) discount program*

- Provided by Healthways WholeHealth Networks (HWHN), with more than 25,000 practitioners.

To access CAM services:

- Participating providers can be found at **http://humana.wholehealthmd.com**.
- Select a provider through the Health & Wellness link of the Savings Center or call the Customer Care number on your member ID card.
- Present the Humana discount card below to receive the specified discount

It's that easy!

You don't need a referral to visit a participating massage therapist, acupuncturist, or chiropractor. However, some Humana health plans offer coverage for some CAM services, so use your insured benefits whenever possible.

**Not available in Arkansas, Tennessee, Oklahoma and where prohibited by law.*

Medication Savings

- Save on over-the-counter (OTC) medications for a wide range of conditions
- Visit the drug coverage search to find alternatives and compare estimated costs for your prescriptions
- Sign up for RightSourceRx℠ to get your prescriptions by mail and save time and money

Stretch your health care dollars

Get special discounts just for Humana members on a wide variety of products and programs, from fitness facilities and weight management programs to tobacco cessation and herbal teas and supplements. Check out the Health & Wellness link for a complete list.

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