



2016 Summary of Benefits

Your Health Benefits

Hamilton County

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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
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Humana Privacy Office
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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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)



[Humana.com](https://www.humana.com)

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

National POS CoverageFirstSM

Hamilton County – CoverageFirst 1000

OHIO

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)

NATIONAL POS COVERAGE FIRST 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) | 100% | 50% after deductible |
| • 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 | | |
| • 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) | 100% after \$20 primary care physician/ \$35 specialist copayment per visit | 50% after deductible |
| • Prenatal benefit (office visit copayment applies to first visit only) | | |
| • Allergy testing (covered as part of office visit) | | |
| • Physician visits to emergency room (3) | 100% | 100% |
| • Diagnostic tests, lab and X-rays (when done in office by physician) | 100% | 50% after deductible |
| • Allergy serum | | |
| • Inpatient services | 80% after deductible | 50% after deductible |
| • Outpatient services | | |
| • 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) | 80% after deductible | 50% after deductible |
| • Outpatient surgery – facility | | |
| • Outpatient nonsurgical care | | |
| • 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) | 80% after deductible | 50% after deductible |
| • 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) | | |
| • Ambulance (3) | 80% after deductible | 80% after participating deductible |

NATIONAL POS COVERAGE FIRST 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 | Same as any other covered condition | Same as any other covered condition |
| • Outpatient therapy sessions | | |

Prior authorization - Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at Humana.com/members/tools/ or call Customer Service.

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

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

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

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.

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National POS CoverageFirstSM

Hamilton County – CoverageFirst 2500

OHIO

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)

NATIONAL POS COVERAGE FIRST 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) | 100% | 70% after deductible |
| • 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 | | |
| • 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) | 100% after \$25 primary care physician/ \$40 specialist copayment per visit | 70% after deductible |
| • Prenatal benefit (office visit copayment applies to first visit only) | | |
| • Allergy testing (covered as part of office visit) | | |
| • Physician visits to emergency room (3) | 100% | 100% |
| • Diagnostic tests, lab and X-rays (when done in office by physician) | 100% | 70% after deductible |
| • Allergy serum | | |
| • Inpatient services | 100% after deductible | 70% after deductible |
| • Outpatient services | | |
| • 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) | 100% after deductible | 70% after deductible |
| • Outpatient surgery – facility | | |
| • Outpatient nonsurgical care | | |
| • 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) | 100% after deductible | 70% after deductible |
| • 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) | | |
| • Ambulance (3) | 100% after deductible | 100% after participating deductible |
| • Chiropractic (25 visits per calendar year) | Same as specialist copayment | 70% after deductible |

NATIONAL POS COVERAGE FIRST 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 | Same as any other covered condition | Same as any other covered condition |
| • Outpatient therapy sessions | | |

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- (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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Humana National POS

Hamilton County – POS 500

OHIO

NATIONAL POS COPAYMENT 90/60 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 (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 |
| <ul style="list-style-type: none">• Vision exam (refraction limited to one per 24 months) | 100% after \$45 copayment | 60% 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 \$30 primary care physician/ \$45 specialist copayment per visit | 60% after deductible |
| <ul style="list-style-type: none">• Inpatient services• Outpatient services (includes surgery)• Office surgery | 90% after deductible | 60% after deductible |
| <ul style="list-style-type: none">• Emergency room physician visits (2) | 100% | 100% |
| <ul style="list-style-type: none">• 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

| | | |
|---|--------------------------------------|--------------------------------------|
| <ul style="list-style-type: none"> 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 |
| <ul style="list-style-type: none"> 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)

| | | |
|--|---|---|
| <ul style="list-style-type: none"> 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 |
| <ul style="list-style-type: none"> Urgent care facility Chiropractic services (subject to 25 visits per calendar year) | 100% after \$75 copayment per visit 100% after specialist copayment per visit | 60% after deductible 60% after deductible |
| <ul style="list-style-type: none"> Ambulance (2) Transplant services | 90% after deductible 90% after deductible (when services are received from a Humana Transplant Network Provider) | 90% after participating deductible 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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[Humana.com](https://www.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.com](https://www.humana.com)

Humana Vision Care Plan (VCP): how it works



Case study:

Sarah's vision expenses for the year totaled \$379 – \$469 without Humana VCP.

With vision coverage, Sarah paid \$56 for an exam and single-vision eyeglasses with standard scratch-resistant coating and standard UV coating. She saved \$323 – \$413, more than 80 percent of the total retail cost.

With Humana VCP options, employees gain access to one of the largest networks in the United States, with more than 35,000 provider locations including independent optometrists and ophthalmologists as well as the five largest retail stores in the nation - Target®, Sears®, JCPenney®, Lenscrafters® and Pearle VisionSM. They also save on examinations, frames, lenses or contact lenses, and popular lens options.

Example 1: Sarah – single coverage, VCP plan

- \$10 exam copayment
- \$15 standard lenses copayment
- \$50 wholesale frame allowance
- \$150 contact lens allowance
- Frequencies:
 - Examination: once every 12 months
 - Lenses or contact lenses: once every 12 months
 - Frames: once every 24 months

Sarah goes to her optometrist for an eye exam:

- Exam with dilation as necessary: \$79 - \$119
- Sarah pays exam copayment: \$10
- **Savings on exam: \$69 – \$109**

| | RETAIL COST ¹ | MEMBER COST | MEMBER SAVINGS |
|-------------------------------------|--------------------------|-------------|------------------|
| \$50 wholesale frame allowance | \$150 ² | \$0 | \$150 |
| Single-vision standard lenses | \$70-\$120 | \$15 | \$55-\$105 |
| Standard scratch-resistance coating | \$40 | \$16 | \$24 |
| Standard UV coating | \$40 | \$15 | \$25 |
| Total savings | \$300-\$350 | \$46 | \$254-304 |

¹ Based on national average. Average retail costs may vary by provider and location.

² Frame retail cost based on three times the wholesale cost. Examples are for illustration only. Actual savings may vary.



Example 2: Sam – single coverage, VCP plan

- \$10 exam copayment
- \$15 standard lenses copayment
- \$50 wholesale frame allowance
- \$150 contact lens allowance
- Frequencies:
 - Examination: once every 12 months
 - Lenses or contact lenses: once every 12 months
 - Frames: once every 24 months

Sam goes to his optometrist for an eye exam:

- Exam with dilation as necessary: \$79 - \$119
- Sam pays exam copayment: \$10
- Savings on exam: \$69 – \$109

Case study:

Sam’s vision expenses for the year totaled \$873 – \$913 without Humana VCP. With vision coverage, Sam paid \$337 for an exam; frames; Varilux Comfort® (premium progressive lenses); Crizal Avancé™ with Scotchguard™ protector and Transitions® lenses, a photochromic tint. He saved \$558 – \$598, more than 65 percent of the total retail cost.

| | RETAIL COST ¹ | WHOLESALE COST | WHOLESALE ALLOWANCE | MEMBER PAYS ² | SAVINGS WITH VCP |
|--------|--------------------------|----------------|---------------------|--------------------------|------------------|
| Frames | \$225 | \$75 | \$50 | (\$25x2)=\$50 | \$175 |

| | RETAIL COST ³ | MEMBER COST | MEMBER SAVINGS |
|---|--------------------------|--------------|----------------|
| Varilux Comfort® (premium progressive lenses) | \$250 | \$94 | \$168 |
| Crizal Avancé™ with Scotchguard Protector | \$199 | \$105 | \$114 |
| Transitions® lenses (photochromic tint) | \$120 | \$88 | \$32 |
| Total | \$569 | \$287 | \$314 |
| Frames (see chart above) | \$225 | \$50 | \$175 |
| | \$794 | \$337 | \$489 |

¹ Frame retail cost based on three times the wholesale cost.

² Member pays twice the difference between the wholesale price and wholesale allowance.

³ Based on national average. Average retail costs may vary by provider and location. Examples are for illustration only. Actual savings may vary.

HumanaVision

Vision Care Plan

Hamilton County 2016

See a participating provider

Exam with dilation as necessary 100% after \$10 copay

Lenses

- Single 100% after \$25 copay
- Bifocal 100% after \$25 copay
- Trifocal 100% after \$25 copay

Frames \$50 wholesale allowance

Contact lenses¹

- Elective (conventional and disposable)² \$110 allowance
- Medically necessary (limit one pair)³ 100%

Frequency (based on date of service)

- Examination Once every 12 months
- Lenses or contact lenses Once every 12 months
- Frame Once every 24 months

Additional plan discounts

- Members receive additional fixed copayments on lens options including: anti-reflective and scratch-resistant coatings.
- Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam and available through the network provider who sold the initial pair of eyeglasses.
- After copay, standard polycarbonate available at no charge for dependents less than 19 years old.

¹ If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames) (Vision Care Plan only).

² The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members receive a 15 percent discount on in-network professional services. The discount for professional services is available for 12 months after the covered eye exam.

³ Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior plan authorization.

Vision Care Plan

HumanaVision Lasik discount

We have contracted with many well-known facilities and eye doctors to offer Lasik procedures at substantially reduced fees. You can take advantage of these low fees when procedures are done by network providers. The network locations listed below offer the following prices (per eye):

| | Conventional / Traditional | | Custom | |
|---|---|--|---|---|
| TLC 888-358-3937 (designated locations only) | \$895 | | \$1,295 | \$1,895* |
| LasikPlus 866-757-8082 | \$695* LasikPlus free enhancements for 1 year | \$1,395* LasikPlus free enhancements for life | \$1,895* LasikPlus free enhancements for life | |
| QualSight LASIK 855-456-2020 | \$895 QualSight free enhancements for 1 year | \$1,295 with QualSight Lifetime Assurance Plan | \$1,320 | \$1,995* with QualSight Lifetime Assurance Plan |

You can also use independent Lasik provider network doctors to receive a 10% discount from usual and customary prices and pay no more than \$1,800 per eye for Conventional Lasik and \$2,300 per eye for Custom Lasik.

*with IntraLase™

How does the wholesale frame allowance work?

Benefits include a wholesale frame allowance. If the wholesale cost exceeds the frame allowance, members pay twice the wholesale difference. They never pay full retail.

| Retail price* | Wholesale price | Wholesale allowance | Member pays | Savings |
|---------------|-----------------|---------------------|------------------------------|----------|
| \$125 | \$50 | \$50 | \$0 | \$125 |
| \$187.50 | \$75 | \$50 | \$50 (\$75-\$50=\$25x2=\$50) | \$137.50 |

* Retail costs may differ and are based on 2½ times the wholesale cost. Actual savings may vary.

Use your HumanaVision benefits

HumanaVision options have you covered and make eye care affordable. You have access to one of the largest vision networks in the United States, with more than 35,000 participating optometrist, ophthalmologists, and national retail locations, including LensCrafters®, Pearle Vision®, Sears® Optical, Target® Optical, and JCPenney® Optical. In addition you'll enjoy:

- The same benefits at all participating providers, no matter where they're located
- Wholesale pricing on frames, avoiding high retail markups
- Simple access to plan information, provider search, Customer Care and other automated services at **HumanaVisionCare.com**

How it Works

1. After signing up for your vision plan, you will receive an ID card in the mail
2. Prior to scheduling your appointment, select a network provider through the Customer Care Center, automated information line, or **HumanaVisionCare.com**
3. Schedule an appointment, providing your name, the patient's name and employer
4. Sign your provider's form after your exam, you'll pay any copayments and/or costs of any upgrades at this time



Know what your plan covers

Attached is a summary of HumanaVision benefits that are described in detail in your certificate. You can find your certificate on HumanaVisionCare.com or call 1-866-537-0229. Here's what you can expect:

- Quality routine eye health care from independent eye care professionals and national retail locations.
- Services and materials provided on a prepaid basis, and the plan pays in-network providers directly, you also have the freedom to use out-of-network providers if you prefer
- Life without claim forms! With HumanaVision, you pay your eye care professional directly for copayments and any extra cosmetic options selected at the time of service
- Select a vision provider from our network simply by visiting HumanaVisionCare.com, if you prefer, call us at 1-866-537-0229

Know what your plan doesn't cover

Some items and services not included in HumanaVision are:

- Orthoptics or vision training, subnormal vision aids or Plano (non-prescription) lenses
- Replacement of lost or broken lenses, except at the regularly-scheduled plan intervals
- Medical or surgical treatment of eyes
- Care provided through or required by any government agency or program, including Workers' Compensation or a similar law

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.

This is not a complete disclosure of plan qualifications and limitations.

Check with your local Humana or HumanaDental sales office to verify product availability.

Insured by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, CompBenefits Insurance Company, or The Dental Concern, Inc.



MyHumana

Register now at [Humana.com](https://www.humana.com)



Find your personalized health and benefits information in one place – MyHumana

As a Humana member, you have a secure website on [Humana.com](https://www.humana.com) called MyHumana. With MyHumana, you have fast, easy access to your personalized benefits information, planning tools, and wellness resources.

Some of what you can do on MyHumana:

- Claims – Check if a claim has been paid along with your estimated cost, if any
- Coverage details – Review deductibles, coverage levels, and limits
- Provider search – Use Physician Finder Plus to find in-network providers near you
- Humana’s MyChoice ToolsSM – Choose providers wisely and estimate costs
- Drug Pricing – Look up coverage, estimated prices, and possible alternatives
- Rx Calculator – Plan for out-of-pocket drug costs
- Health and Condition Centers – Access health information specific to your conditions and life stage
- Year-to-Date Summary – See an at-a-glance view of your financial information – including balances in your Health Savings Account, Flexible Spending Account, or Personal Care Account and amounts applied to deductibles
- Manage access – Give other adults on your policy permission to access your health information
- Update your communications preferences – Select which communications you want to receive from Humana and how you want to receive them – via paper or e-mail



Registering is easy

- Have your Humana ID card ready
- Go to [Humana.com](https://www.humana.com)
- Select “Register” at the top of the page or in the log-in box on the left
- Choose “Member all other plan types”
- Fill in some basic information – like your member ID number, date of birth, ZIP code, and e-mail address, and click “next”
- Create a User ID, password, and security prompt and click “next” to finish

Now, how easy was that? You’re all set – jump in and start exploring!

You don’t have to wait for health and benefits guidance – you can get it right away with MyHumana.

Please note, all features may not be available to all members.

Humana[®]

[Humana.com](https://www.humana.com)

MyHumana Mobile app

“Now we go where you go”

Access your health information anytime, anywhere

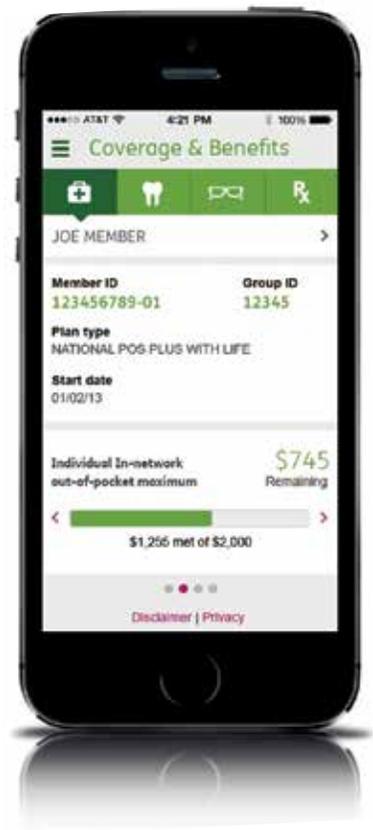
Whether you prefer downloading a mobile application, using your mobile device or receiving text messages, you have the ability to manage your healthcare needs virtually anywhere, anytime.

Use the MyHumana Mobile app and website to:

- View medical, dental, vision, and pharmacy claims
- View your plans and coverage details
- View your HumanaVitality® Dashboard†
- Receive medication reminders
- Research drug prices
- Locate providers in your network
- Refill your RightSource® prescriptions

Download the Mobile App:

Download the MyHumana Mobile app from your app store. Search “MyHumana” in the Google Play or App Store.



From your mobile device's browser:

You can visit MyHumana from your mobile device's browser. To get started, go to **Humana.com** and sign-in.

Text message alerts*

On the MyHumana Mobile app:

1. Register or Sign in
2. Click on the Menu icon
3. Select Text Alerts
4. Register and verify your Mobile #
5. Select the alerts you want to receive

On Humana.com:

1. Register or Sign in
2. Click on Account settings & preferences
3. Select Edit your preferences
4. Select Mobile from the tab
5. Register and verify your Mobile #
6. Select the alerts you want to receive

†Available to HumanaVitality members only.

*Message and data rates may apply.

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