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

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

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

If you are a Humana Member now...

Log in to www.Humana.com
- If this is your first time logging in, you'll need to register.
  To do this:
  - You'll need your Humana member id to register.
  - If you do not have an email address, type: nomail@humana.com

Click on:
- Resources & Support

Then, click on:
- Health Resources

Then, click on:
- Health Assessment

If you are NOT a Humana Member yet...

Log in to www.Humana.com/hha and click on:
- Take the Assessment

- Click the “Employer” box and select “Pflugerville Independent School District”
- Type in the requested information
- All items with a red asterisk * are required
- If you do not have an email address then type nomail@humana.com
- Confirm the information you typed
- Click on

Pictures may vary; look for the specified text in the area identified.

Please turn to the back for additional information on the Humana Health Assessment.
Whether you access the Humana Health Assessment through MyHumana or www.humana.com/hhha you need to:

- If you see the message below, disable your “Pop Up blocker” & select “Always allow pop-ups for this application”

Scroll down and click “I agree”, then click:

Read the disclaimer and click “Accept”, then click:

You are ready to begin the questionnaire.

You are done when you see your summary scores.

Print this page. Also scroll down to the bottom of the page & record your confirmation number.

Be sure to click the EXIT button in the top right corner.

Congratulations!
# PISD Monthly Rate Summary

**Effective January 1, 2013**

## Coverage 1st Plan

<table>
<thead>
<tr>
<th></th>
<th>Premium</th>
<th>PISD Contribution</th>
<th>Employee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE Only</td>
<td>$359</td>
<td>$344</td>
<td>$15</td>
</tr>
<tr>
<td>EE + SP</td>
<td>$658</td>
<td>$344</td>
<td>$314</td>
</tr>
<tr>
<td>EE + CH</td>
<td>$608</td>
<td>$344</td>
<td>$264</td>
</tr>
<tr>
<td>EE + FAM</td>
<td>$953</td>
<td>$344</td>
<td>$609</td>
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## Medical LOW Plan

<table>
<thead>
<tr>
<th></th>
<th>Premium</th>
<th>PISD Contribution</th>
<th>Employee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE Only</td>
<td>$368</td>
<td>$344</td>
<td>$24</td>
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<tr>
<td>EE + SP</td>
<td>$676</td>
<td>$344</td>
<td>$332</td>
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<tr>
<td>EE + CH</td>
<td>$625</td>
<td>$344</td>
<td>$281</td>
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<tr>
<td>EE + FAM</td>
<td>$980</td>
<td>$344</td>
<td>$636</td>
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## Medical MIDDLE Plan

<table>
<thead>
<tr>
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<th>Premium</th>
<th>PISD Contribution</th>
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</tr>
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<tbody>
<tr>
<td>EE Only</td>
<td>$444</td>
<td>$344</td>
<td>$100</td>
</tr>
<tr>
<td>EE + SP</td>
<td>$853</td>
<td>$344</td>
<td>$509</td>
</tr>
<tr>
<td>EE + CH</td>
<td>$785</td>
<td>$344</td>
<td>$441</td>
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<td>EE + FAM</td>
<td>$1,197</td>
<td>$344</td>
<td>$853</td>
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## Medical HIGH Plan

<table>
<thead>
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<th>Premium</th>
<th>PISD Contribution</th>
<th>Employee Contribution</th>
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<tbody>
<tr>
<td>EE Only</td>
<td>$540</td>
<td>$344</td>
<td>$196</td>
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<tr>
<td>EE + SP</td>
<td>$1,054</td>
<td>$344</td>
<td>$710</td>
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<tr>
<td>EE + CH</td>
<td>$969</td>
<td>$344</td>
<td>$625</td>
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<tr>
<td>EE + FAM</td>
<td>$1,450</td>
<td>$344</td>
<td>$1,106</td>
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<tr>
<td>Medical Benefits</td>
<td>Low Plan</td>
<td>Mid Plan</td>
<td>High Plan</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Benefit Allowance</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,150</td>
<td>$1,400</td>
<td>$650</td>
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<tr>
<td>Family</td>
<td>$4,300</td>
<td>$2,800</td>
<td>$1,300</td>
</tr>
<tr>
<td>Co-Insurance</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Co-Insurance Maximum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,000</td>
<td>$3,000</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$12,000</td>
<td>$6,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Routine Physical Exam &amp; Routine Child Care</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
</tr>
<tr>
<td>Routine Mammogram</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
</tr>
<tr>
<td>Routine Colonoscopy</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
</tr>
<tr>
<td>Routine Lab &amp; X-ray</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
</tr>
<tr>
<td>Vision Exam (1 every 12 months)</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td>$30 copay</td>
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<tr>
<td>Office Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary &amp; Specialist</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$40 copay</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility &amp; Physician Services</td>
<td>70% after deductible</td>
<td>80% after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>70% after deductible</td>
<td>80% after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Emergency - Facility</td>
<td>$150 copay</td>
<td>$150 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Emergency - Physician</td>
<td>70% after deductible</td>
<td>80% after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Lab / X-Ray</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billed By Doctors Office (1)</td>
<td>Included in office copay</td>
<td>Included in office copay</td>
<td>Included in office copay</td>
</tr>
<tr>
<td>Billed By Outside Facility (1)</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
<td>100% no deductible</td>
</tr>
<tr>
<td>Physical Therapy/Occupational Therapy/Chiropractic Services</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Prescriptions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail (30 days)</td>
<td>$10 / $40 / $60</td>
<td>$10 / $40 / $60</td>
<td>$10 / $30 / $50</td>
</tr>
<tr>
<td>Mail Order (90 days)</td>
<td>$25 / $100 / $150</td>
<td>$25 / $100 / $150</td>
<td>$25 / $75 / $125</td>
</tr>
</tbody>
</table>

*See your Humana Summary of Benefits for Out of Network benefit levels. Provider Search: Log on to www.humana.com to find a provider. You will select the NPOS - Open Access network. (1) Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram & PET Scan are subject to deductible and coinsurance. If a procedure is in question, please contact Customer Service at 1-800-4HUMANA (1-800-448-6262) with the diagnosis and procedure code. This summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. Please refer to your Summary of Benefits and Summary Plan Description for a complete listing of services, limitations and exclusions. If there is a conflict in the benefits, Summary Plan Description will prevail.
What is National POS – Open Access?
With National POS – Open Access you can see any provider without a referral. What makes National POS – Open Access unique is that you have access to more doctors and other medical providers than other Humana plans. It's the plan you've been asking for.

Why you might want National POS – Open Access
• No referrals
• More doctors and providers
• Nationwide coverage

You can see any doctor without a referral. With Humana’s National POS – Open Access you can see any doctor or specialist without a referral from your primary care doctor – but your costs are usually lower when you use in-network providers.

You can take advantage of Humana’s discounted rates wherever you are. No matter what type of plan you have, National POS – Open Access offers Humana’s contracted rates with doctors in our HMO and ChoiceCare networks. Providers are available in all 50 states and Washington, D.C.

Questions and answers
1. I signed up for National POS – Open Access. What else should I do?
   That's all you need to do for now. You'll receive a Humana ID card in the mail before your plan year begins. If you signed up for a Flexible Spending Account your HumanaAccess card will be your ID card.

2. How do I know if my doctor participates in National POS – Open Access?
   Use the Physician Finder Plus tool on Humana.com to look up doctors in your network. Just search under “National POS – Open Access.” Remember, you can see any doctor you want without referral. However, you’ll usually pay less when you use in-network doctors.

3. Is National POS – Open Access available when I travel?
   You can use your plan with reciprocity in all fifty states. National POS – Open Access is a great plan for members with dependents in other covered areas. Employers with employees in different locations select this offering so they can offer all employees the same benefits.

Refer to your Summary Plan Description or Certificate of Coverage for details about your plan.


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.
Simplify your search from start to finish:
• Find the most recently updated list of in-network providers – quickly and easily
• Get provider phone numbers, addresses, and maps
• Customize your search by specialty and other criteria, as well as by distance from your home or work
• Save time with the “Find a certain provider” feature – look up a person, group, or facility by name, then see if the provider is in your network

It’s easy to use Physician Finder Plus:
Go to Humana.com and click on “find a doctor”. Choose a provider type under “Provider Search” on the right side of the page, or click on “Find a Doctor” in the middle of the page.

1. Select your coverage. If you know your member ID number, enter it on the left side of the page. If you don’t have your member ID number, you can select your type of coverage and enter your ZIP code, then select your network from a drop-down box. You may have several options – if you’re not sure which one to choose, call the Customer Care number on your Humana ID card or check with your company benefits administrator.

2. Enter your location. You can search for providers near a certain ZIP code or, if you prefer, within a particular county. Don’t forget to agree to the Terms of Use on this page, too.

3. Select a provider type. Click on the type of provider you need. The options vary depending on whether you’re looking for a doctor, hospital, urgent care center, or other healthcare provider. For instance, if you’re searching for a doctor, you can choose primary care physician or specialist and then choose a particular specialty. Click on “Advanced Search” to pinpoint by gender, certifications, languages spoken, and more.

4. Get your search results. Click a name to see contact information, a map, and directions. You also can create a PDF of your search results and print your results in an easy-to-read format.
# National POS CoverageFirst<sup>SM</sup>
## Pflugerville ISD - Coverage First Plan
### Texas

<table>
<thead>
<tr>
<th>NATIONAL POS COVERAGEFIRST COPayment 70/50 PLAN</th>
<th>PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS</th>
<th>PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Up-front Benefit Allowance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual member benefit (Applies to medical services received from participating providers only. Does not apply to member copayments.)</td>
<td>$500 per calendar year per member</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Annual Deductible (per calendar year; copayments do not apply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>$3,150</td>
<td>$9,000</td>
</tr>
<tr>
<td>• Family (1)</td>
<td>$6,300</td>
<td>$18,000</td>
</tr>
<tr>
<td><strong>Preventive Care (Does not reduce the benefit allowance)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual routine adult physical exam (18 years and above)</td>
<td>100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Routine child care (up to age 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine immunizations (age 6 to age 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine mammography and Pap smears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine outpatient laboratory tests/X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)</td>
<td>100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Routine immunizations (birth to age 6)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office visits (excludes diagnostic lab and X-ray)</td>
<td>100% after $30 primary care physician/ $30 specialist copayment per visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Prenatal benefit (office visit copayment applies to first visit only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allergy testing (covered as part of office visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostic tests, lab and X-rays (when done in office by physician)</td>
<td>100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Allergy serum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient services</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>• Outpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician visits to emergency room (2)</td>
<td>70% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Allergy injections and nonroutine injections other than allergy</td>
<td>100% after copayment per visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>NATIONAL POS COVERAGE FIRST COPAYMENT 70/50 PLAN</td>
<td>PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS</td>
<td>PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient care (semiprivate room and board, nursing care, ICU)</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>• Outpatient surgery – facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient nonsurgical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency room visit (copayment is waived if admitted) (2)</td>
<td>100% after $150 copayment per visit</td>
<td>100% after $150 copayment per visit</td>
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<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Please see attached pharmacy benefit information, if applicable</td>
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</tr>
<tr>
<td><strong>Other Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Skilled nursing facility (up to 60 days per calendar year)</td>
<td>70% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Home health care (subject to 60 visits per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical and occupational therapy</td>
<td>100% after $30 copayment per visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>(separate 20 visits maximum per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chiropractic (up to 20 visits per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Speech and cognitive therapy</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>• Durable medical equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ambulance (2)</td>
<td>70% after deductible</td>
<td>70% after participating deductible</td>
</tr>
<tr>
<td>• Urgent care</td>
<td>100% after $40 copayment per visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Transplant services</td>
<td>70% after deductible (when services are received from a Humana Transplant Network Provider)</td>
<td>50% after deductible (covered expenses are limited to a maximum benefit of $35,000 per transplant)</td>
</tr>
<tr>
<td><strong>Behavioral Health (mental health and substance abuse services)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient services</td>
<td>Same as any other covered condition</td>
<td>Same as any other covered condition</td>
</tr>
<tr>
<td>• Inpatient professional services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient therapy sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Serious Mental Illness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient services</td>
<td>Covered the same as any other illness</td>
<td>Covered the same as any other illness</td>
</tr>
<tr>
<td>• Outpatient therapy and office therapy sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Out-Of-Pocket Expense Limit</strong> (per calendar year; excludes deductibles and copayments)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>$6,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>• Family</td>
<td>$12,000</td>
<td>$36,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>Unlimited (participating and nonparticipating combined)</td>
<td></td>
</tr>
</tbody>
</table>
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) 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.
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: $10
  - Level Two: $35
  - Level Three: $55
  - Level Four: 25%* of the total required payment to the dispensing pharmacy per prescription or refill.

  *The total maximum out-of-pocket copayment costs for drugs in Level Four is limited to $2,500 per calendar year, per member.
  - 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 default rate.
  - 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 and 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.
- 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.
- Default rate: the rate or amount equal to the Medicare reimbursement rate for the prescription or refill.
- 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.

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.

HUMANA.


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

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

Our health benefit plans have limitations and exclusions
# Preventive Care (1)
- Routine immunizations (birth to age 6) 100% 100%
- Routine immunizations (age 6 to age 18) 100% 70% after deductible
- Routine Pap smear
- Annual routine mammogram
- Routine lab test and X-ray
- Routine adult physical exam (18 years and above)
- Routine child exams (to age 18)
- Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)

# Physician Services (1)
- Office visits 100% after $30 primary care physician/ $30 specialist copayment per visit 70% after deductible
- Diagnostic, lab and X-rays (copayment does not apply)
- Allergy testing (copayment does not apply)
- Inpatient services 70% after deductible 50% after deductible
- Outpatient services (includes surgery)
- Office surgery 100% after office visit copayment 70% after deductible
- Emergency room physician visits (2) 70% after deductible 70% after deductible
- Allergy injections and nonroutine injections other than allergy 100% after copayment per visit 70% after deductible

# Facility Services
- Inpatient services 70% after deductible 50% after deductible
- Outpatient surgery
- Outpatient nonsurgical care (does not include advanced imaging)
- Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) 100% 70% after deductible
- Lab and X-ray in other outpatient facilities (excluding certain diagnostic procedures, ie. advanced imaging)
- Hospital emergency services (emergency room copayment waived if admitted) 100% after $150 copayment per visit (2) 100% after $150 copayment per visit (2)
<table>
<thead>
<tr>
<th>NATIONAL POS COPAYMENT 70/50 PLAN</th>
<th>PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS</th>
<th>PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Please see attached pharmacy benefit information, if applicable</td>
<td></td>
</tr>
<tr>
<td><em>(includes oral contraceptives)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Medical Services (3)

- Skilled nursing facility (up to 60 day limit per calendar year): 70% after deductible
- Home health (subject to 60 visits per calendar year): 70% after deductible
- Physical and occupational therapy (separate 20 visits maximum per calendar year): 100% after $30 copayment per visit or 70% after deductible
- Chiropractic services (up to 20 visits per calendar year): 100% after $30 copayment per visit or 70% after deductible
- Speech and cognitive therapy: 70% after deductible
- Durable medical equipment: 70% after deductible
- Urgent care facility: 100% after $40 copayment per visit or 70% after deductible
- Ambulance (2): 70% after deductible or 70% after participating deductible
- Transplant services: 70% after deductible (when services are received from a Humana Transplant Network Provider) or 50% after deductible (covered expenses are limited to a maximum benefit of $35,000 per transplant)

### Deductible and Out-of-Pocket Maximum Accumulation Methods

<table>
<thead>
<tr>
<th>Deductible (per calendar year; copayments do not apply)</th>
<th>Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (includes fourth quarter carryover)</td>
<td>$2,150 $4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,300 $8,000</td>
</tr>
</tbody>
</table>

### Out-of-Pocket Maximum (per calendar year; deductibles and copayments do not apply)

| Individual                                              | $6,000 $12,000                                                                                  |
| Family                                                  | $12,000 $24,000                                                                                 |

### Lifetime Maximum Benefit

<table>
<thead>
<tr>
<th>Behavioral Health (mental health and substance abuse)</th>
<th>Unlimited (participating and nonparticipating combined)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services</td>
<td>Same as any other illness</td>
</tr>
<tr>
<td>Outpatient therapy sessions</td>
<td>Same as any other illness</td>
</tr>
</tbody>
</table>

### Serious Mental Illness

<table>
<thead>
<tr>
<th>Serious Mental Illness</th>
<th>Covered same as any other illness</th>
</tr>
</thead>
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<tr>
<td>Inpatient services</td>
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</tr>
<tr>
<td>Outpatient therapy and office therapy sessions</td>
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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) 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.
(3) Visit and day limits are combined for participating and nonparticipating providers.

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.

Administered by Humana Health Plan, Inc.

Humana.com
### Preventive Care (1)

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<td>$2,800</td>
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<td></td>
</tr>
<tr>
<td>- Individual</td>
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<tr>
<td>- Family</td>
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Payments
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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 Summary Plan Description 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 Summary Plan Description.
(3) Visit and day limits are combined for participating and nonparticipating providers.

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.
How the Rx3 structure works

When you present your membership card at a participating pharmacy, you will be required to make a copayment for your prescriptions based on the type of medication you purchase:

- **Level One**: Lowest copayment for low-cost generic drugs.
- **Level Two**: Higher copayment for higher-cost brand-name drugs.*
- **Level Three**: Highest copayment for higher-cost drugs, both generic and brand-names. These drugs may have generic or brand-name alternatives in Levels One or Two.*

* 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 Rx3 Drug List by mail.

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<tr>
<th>Coverage at participating pharmacies</th>
<th>Copayment per prescription or refill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs assigned to:</td>
<td></td>
</tr>
<tr>
<td>Level One:</td>
<td>$10</td>
</tr>
<tr>
<td>Level Two:</td>
<td>$40</td>
</tr>
<tr>
<td>Level Three:</td>
<td>$60</td>
</tr>
</tbody>
</table>

- 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 membership 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 actual charges**
  - You file a claim form with Humana (address is on the back of ID card)
  - Claim is paid at 70 percent of the actual charges, after they are first reduced by the sum of the applicable copayment and any required difference between the amount paid by Humana to the dispensing pharmacy for the brand-name drug and the amount Humana would have paid the dispensing pharmacy for a generic medication

- **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
Limitations and
90-day Retail

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 approved by Humana will be paid at the applicable copayment
- 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 and 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 90-day basis. Members can call Customer Service or visit our Website for more information, including mail-order forms.

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.
- 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.
- 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.
- Nonparticipating pharmacy: a pharmacy that has not been designated by us to provide services to covered persons.

Limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

- Any drug prescribed for a sickness or bodily injury not covered under the master group contract.
- Any drug, medicine or medication labeled “Caution – limited by federal law to investigational use” or any experimental or investigational drug, medicine or medication, even though a charge is made to you.
  {WI – This does not apply to those investigational drugs which are approved by the FDA for treatment of HIV infection or a medical condition arising from or related to, and that has completed a Phase III clinical investigation.}
- Anorectic or any drug used for the purpose of weight control.
- Any drug used for cosmetic purposes, including but not limited to {IN – remove but not limited to}:
  - Tretinoin, e.g. Retin A, except if you are under the age of 45 or are diagnosed as having adult acne;
  - Dermatologics or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents, e.g. Solaquin.
- Any drug or medicine that is:
  - Lawfully obtainable without a prescription (over the counter drugs), except insulin {LA – insulin covered under diabetes benefit}; or
  - Available in prescription strength without a prescription.
- Abortifacients (drugs used to induce abortions).
- Infertility services including medications. {IL – This exclusion is removed.} {OH – Medications for infertility services.} {TX – Fertility medications.}
- Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra.
• Any drug for which prior authorization is required, as determined by us, and not obtained.
• Any service, supply, or therapy to eliminate or reduce a dependency on, or addiction to tobacco, and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services, or medications {IN – remove but not limited to}.
• Treatment for onychomycosis (nail fungus).
• Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill.
• Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does not participate in our program which allows you to receive a 90-day supply of a prescription or refill.
• Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us.
• Legend drugs which are not deemed medically necessary by us.
• Prescriptions filled at a non-network pharmacy except for prescriptions required during an emergency.
• More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner.)
• These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply or prescription. This does not prevent your health care practitioner or pharmacist from providing or performing the procedure, service, treatment, supply or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.

This is only a partial list of limitations and exclusions. Please refer to the Benefit Plan Document for complete details regarding prescription drug coverage.
### Preventive Care (1)
- Routine immunizations (birth to age 6) 100%
- Routine immunizations (age 6 to age 18) 100%
- Routine Pap smear
- Annual routine mammogram
- Routine lab test and X-ray
- Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)
- Routine adult physical exam (18 years and above)
- Routine child exams (to age 18)

### Physician Services (1)
- Office visits 100% after $30 primary care physician/ $30 specialist copayment per visit
- Diagnostic, lab and X-rays (copayment does not apply) 70% after deductible
- Allergy testing
- Inpatient services 90% after deductible
- Outpatient services (includes surgery) 70% after deductible
- Office surgery 100% after office visit copayment 70% after deductible
- Emergency room physician visits (2) 90% after deductible
- Allergy injections and nonroutine injections other than allergy 70% after deductible

### Facility Services
- Inpatient services 90% after deductible
- Outpatient surgery
- Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) 70% after deductible
- Lab and X-ray in other outpatient facilities (excluding certain diagnostic procedures, i.e. advanced imaging) 100%
- Hospital emergency services (emergency room copayment waived if admitted) 100% after $150 copayment per visit (2)

### Prescription Drugs
- (includes oral contraceptives) Please see attached pharmacy benefit information, if applicable

### Other Medical Services (3)
<table>
<thead>
<tr>
<th>NATIONAL POS COPAYMENT 90/70 PLAN</th>
<th>PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS</th>
<th>PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Skilled nursing facility (up to 60 day limit per calendar year)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Home health (subject to 60 visits per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical and occupational therapy (separate 20 visits maximum per calendar year)</td>
<td>100% after $30 copayment per visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Chiropractic services (up to 20 visits per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Durable medical equipment</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Speech and cognitive therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgent care facility</td>
<td>100% after $40 copayment per visit</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>• Ambulance (2)</td>
<td>90% after deductible</td>
<td>90% after participating deductible</td>
</tr>
<tr>
<td>• Transplant services</td>
<td>90% after deductible (when services are received from a Humana Transplant Network Provider)</td>
<td>70% after deductible (covered expenses are limited to a maximum benefit of $35,000 per transplant)</td>
</tr>
</tbody>
</table>

**Deductible and Out-of-Pocket Maximum Accumulation Methods**

<table>
<thead>
<tr>
<th>Deductible (per calendar year; copayments do not apply)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual</td>
<td>$650</td>
<td>$2,000</td>
</tr>
<tr>
<td>• (includes fourth quarter carryover)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family</td>
<td>$1,300</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum (per calendar year; deductibles and copayments do not apply)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual</td>
<td>$1,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>• Family</td>
<td>$3,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

**Lifetime Maximum Benefit**

<table>
<thead>
<tr>
<th></th>
<th>Unlimited (participating and nonparticipating combined)</th>
</tr>
</thead>
</table>

**Behavioral Health** (mental health and substance abuse)

<table>
<thead>
<tr>
<th></th>
<th>Same as any other illness</th>
<th>Same as any other illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient therapy sessions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Serious Mental Illness**

<table>
<thead>
<tr>
<th></th>
<th>Covered same as any other illness</th>
<th>Covered same as any other illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient therapy and office therapy sessions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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) 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.
(3) Visit and day limits are combined for participating and nonparticipating providers.

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.
HumanaPOS Rx3
Level One - $10, Level Two - $30, Level Three - $50

How the Rx3 structure works

When you present your ID card at a participating pharmacy, you will be required to make a copayment for your prescriptions based on the type of medication you purchase:

• **Level One**: Lowest copayment for low-cost generic drugs.
• **Level Two**: Higher copayment for higher-cost brand-name drugs.*
• **Level Three**: Highest copayment for higher-cost drugs, both generic and brand-names. These drugs may have generic or brand-name alternatives in Levels One or Two.*

* 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 Rx3 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:**

<table>
<thead>
<tr>
<th>Level</th>
<th>Copayment per prescription or refill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One</td>
<td>$10</td>
</tr>
<tr>
<td>Level Two</td>
<td>$30</td>
</tr>
<tr>
<td>Level Three</td>
<td>$50</td>
</tr>
</tbody>
</table>

• 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.
• If the dispensing pharmacy’s charge is less than the corresponding copayment, you will only be responsible for the lower amount.

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 default rate
  – 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 approved by Humana will be paid at the applicable copayment
- 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 and 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 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.

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.

HUMANA


Statements in languages other than English contained in the advertisement do not necessarily reflect the exact contents of the policy written in English, because of possible linguistic differences. In the event of a dispute, the policy as written in English is considered the controlling authority.

For Arizona residents: offered by Humana Health Plan, Inc. or insured by Emphesys Insurance Company or insured 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.
Spending too much time filling your prescriptions?

Using RightSourceRx helps you free up your time and money for more important things.

Getting Started with RightSourceRx is Easy as 1... 2... 3...

1 Get a new prescription from your doctor
   - Ask your doctor to write a new prescription for up to a three-month supply and to indicate the number of refills. If you need your medication right away, ask your doctor for two prescriptions; one written for a one-month supply you can fill at a retail pharmacy in Humana’s network and the second written for up to a three-month supply that you can send to RightSourceRx.
   - Make sure the medication prescribed by your doctor is covered by your Humana prescription drug plan – you can check your plan benefit materials or the drug lists on Humana.com.

2 Submit your order and payment
   For fastest service, your doctor can submit your new prescriptions to RightSourceRx by fax or phone.

   Doctors: Fax to 1-800-379-7617 or Call 1-800-379-0092.
   When faxing prescriptions to RightSourceRx, doctors need to fill out the Physician Fax Form. RightSourceRx can only accept fax orders from a doctor.

   Customers: Mail to RightSourceRx, P.O. Box 29200, Phoenix, AZ 85038-9200 Mail us the original paper prescription, a Registration and Prescription Order Form, and payment information. Please include your name, date of birth, Humana ID number, and shipping address on the back of each prescription. Don’t forget to include your payment. Check MyHumana or your benefit materials for mail-order copayment amounts. You can pay with the HumanaAccessSM Visa® Debit Card, or any other Visa, MasterCard, American Express, Discover, money order, or personal check. Don’t send cash.

3 Check Your Mailbox
   You should get your new medication by mail within two weeks. RightSourceRx should notify you with the status of your order by phone or e-mail. Please understand that delivery may take longer if RightSourceRx has to contact you or your prescribing doctor with questions about your order.

Medicare-approved HMO, PPO, PDP and PFFS plans. If you’re a member of a Qualified State Pharmaceutical Assistance Program, please contact the Program to verify that RightSourceRx will coordinate with that program.

Advantages of RightSourceRx

Convenience
   Instead of making a trip to a retail pharmacy every month, you’ll receive up to a three-month supply of your medication delivered to your home by mail.

Safety and Accuracy
   RightSourceRx pharmacists review each new prescription for accuracy and possible drug-to-drug interactions. We also use foil-sealed containers for added safety.

Communication
   RightSourceRx lets you know the status of your order by e-mail or phone; we also notify you when medications are available for refill.

Contact Information

RightSourceRx.com
   RightSourceRx
   P.O. Box 29200
   Phoenix, AZ 85038-9200
   1-800-379-0092
   (TTY: 1-877-833-4486)
   Monday – Friday, 8 a.m. – 11 p.m.
   Saturday, 8 a.m. – 6:30 p.m.
   (Eastern Time)
¿Emplea demasiado tiempo en obtener sus recetas?

Usar RightSourceRx le ayuda a disponer de más tiempo y dinero para cosas más importantes.

Empezar a usar RightSourceRx es muy sencillo.

1. Pídale a su médico que le haga una receta nueva
   - Pídale al médico que le extienda una receta nueva para una provisión de hasta tres meses y que indique la cantidad de repeticiones de la receta médica. Si necesita los medicamentos de inmediato, pídale al médico dos recetas: una para una provisión de un mes que puede obtener en una farmacia minorista de la red de Humana y otra para una provisión de hasta tres meses que puede enviar a RightSourceRx.
   - Asegúrese de que el plan de medicamentos recetados de Humana cubra los medicamentos recetados por el médico. Para verificarlo, consulte los materiales sobre los beneficios del plan o las listas de medicamentos en Humana.com.

2. Envíe su pedido y el pago
   Para obtener un servicio más rápido, el médico puede enviar las recetas nuevas a RightSourceRx por fax o por teléfono.
   **Médicos:** Enviar por fax al 1-800-379-7617 o Llamar al 1-800-379-0092. Cuando envían las recetas a RightSourceRx por fax, los médicos deben completar el Formulario de fax para el médico. RightSourceRx sólo puede aceptar pedidos por fax enviados por los médicos.
   **Clientes:** Enviar por correo a RightSourceRx, P. O. Box 29200, Phoenix, AZ 85038-9200. Envíen la receta original en papel, un Formulario de registro y pedido de medicamentos recetados e información sobre el pago. Incluya su nombre, fecha de nacimiento, número de identificación de Humana y la dirección de envío en la parte posterior de cada receta. No olvide incluir el pago. Consulte MyHumana o los materiales sobre los beneficios para obtener los montos de los copagos de envío por correo. Puede pagar con su tarjeta de débito Humana Access℠ Visa®, o con cualquier otra tarjeta Visa, MasterCard, American Express o Discover; giro postal o cheque personal. No envíe dinero en efectivo.

3. Busque en su buzón de correo
   Debe recibir el medicamento nuevo por correo en el término de dos semanas. RightSourceRx debe notificarle el estado del pedido por teléfono o correo electrónico. Tenga a bien comprender que la entrega puede demorar un poco más si RightSourceRx tiene que comunicarse con usted o con el médico que emite la receta para realizar preguntas sobre el pedido.

Ventajas de RightSourceRx

**Comodidad**
En lugar de tener que ir a la farmacia minorista todos los meses, se le enviará por correo a su hogar una provisión de hasta tres meses del medicamento.

**Seguridad y precisión**
Los farmacéuticos de RightSourceRx revisan cada receta nueva para determinar su precisión y las posibles interacciones con otros medicamentos. También utilizamos recipientes sellados con papel de aluminio para más seguridad.

**Comunicación**
RightSourceRx le permite saber el estado de su pedido por correo electrónico o teléfono; también le notifican cuando los medicamentos están disponibles para la repetición de la receta médica.

Información de contacto

RightSourceRx.com

RightSourceRx
P. O. Box 29200
Phoenix, AZ 85038-9200
1-800-379-0092
(TTY: 1-877-833-4486)

De lunes a viernes, de 8 a. m. a 11 p. m. Sábados, de 8 a. m. a 6:30 p. m. (hora oficial del este)

Planes HMO, PPO, PDP y PFFS aprobados por Medicare. Si está afiliado a un programa estatal calificado de asistencia de farmacia (Qualified State Pharmaceutical Assistance Program, SPAP), póngase en contacto con el programa para verificar que RightSourceRx coordine con ese programa.
Prior Authorization

Right drug, **right dose**, right patient, right reason

Prior authorization (PA) is a process that asks a doctor to get pre-approval before Humana Pharmacy Solutions provides coverage for a prescribed drug. The program allows for care with appropriate rationale for the requested coverage.

To put it simply, a PA promotes the right drug, in the right dose, to the right patient, for the right reason.

**Why have prior authorizations?**
Humana Pharmacy Solutions uses PAs for several reasons:
- Adheres to strong safety warnings issued by the manufacturer or the Food and Drug Administration
- Promotes appropriate diagnosis and population
- Prevents drug abuse or the potential for abuse
- Encourages availability of generic, over-the-counter, or other equally effective alternative
- Reduces cost

**Prior authorization strives for increased safety**
Some drugs have safety warnings and may cause serious, and sometimes life-threatening side effects, while certain pain medications can have abuse potential. Humana Pharmacy Solutions provides information to doctors to help ensure members take the right drug for the right reason.

In addition, PAs help ensure safety parameters, as in the case of specialty medications. These medications typically come at a high cost, are only approved for specific conditions, and usually require patient monitoring. Humana Pharmacy Solutions takes the extra step to monitor these medications. Our PA programs supply information to help doctors provide proper care to the patient to maximize outcomes and minimize side effects.

**The value of prior authorization**
A PA can provide value in several ways. A number of high-cost medications have FDA-approved generics or over-the-counter options, which are just as effective and offer significant savings.

Another example involves a relatively new drug for treating diabetes. We added a PA to this medication because it costs more, but hasn’t shown clinical superiority to other products. In addition, the drug isn’t included in the American Diabetes Association’s recommended treatment procedures. Consumers sometimes think if they pay more, they get more value and higher quality. But in this case, the evidence doesn’t support that theory.

**PAs for one diabetes treatment**

**saved $3.43 million**

in 2007
Frequently asked questions

Q. What’s the basis for prior authorizations?
A. • PA criteria are based on FDA, evidence-based, and manufacturer guidelines, medical literature, safety, appropriate use, benefit design, or cost.
• PAs are placed on selected high-risk or high-cost medications to promote the most appropriate utilization.
• Doctors are sometimes pressured by patients who have seen a drug advertisement and want a specific name brand. A doctor may decide to prescribe a drug because of this pressure. A PA gives the doctor a resource that shows why another drug works. The PA may be a way to combat direct to consumer advertising, which can increase costs.
• Examples: Multi-source brands, lifestyle-enhancement medications, high-risk, and high-cost drugs.

Q. Are PAs an industry-wide practice?
A. • Yes, but some companies use PAs to generate revenue. At Humana Pharmacy Solutions, we add PAs once a year, based on clinical recommendations, not to increase revenue.

Q. Who at Humana Pharmacy Solutions decides a drug needs PA?
A. • Humana Pharmacy Solutions’ Pharmacy & Therapeutics (P&T) Committee makes all Drug List decisions. The P&T Committee is an internal group of doctors, pharmacists, and other healthcare providers from different specialties who make recommendations about safe and effective use of medications.

Q. Is submitting a PA simple?
A. • Yes. Only doctors can submit a PA request. Our online Drug List indicates which medications require PA. Doctors can submit PA requests online and often receive automatic approvals. During the approval process, the doctor answers a series of clinical questions based on criteria for the appropriate use of the respective medication, based on FDA recommendations.
• Doctors can also fax or call Humana Clinical Pharmacy Review to request a PA.

Q. How can members see which drugs require a PA?
A. • Members can access the Drug List on Humana.com, to see which medications require a PA.
Taking Care of Your

**Behavioral Health**

When you or a family member needs a place to turn for mental health or substance abuse issues, your behavioral health program can help – 24 hours a day, seven days a week. Some of the common issues your program addresses include:

- Anxiety
- Depression
- Bipolar disorder
- Alcohol and drug abuse
- And more

We keep all calls, records, and other information confidential, as required by federal and state laws.

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**How the Program Works**

Your health plan’s behavioral health program is coordinated by LifeSynchSM, a wholly owned subsidiary of Humana. LifeSynch has received Full Accreditation for Managed Behavioral Health Organization from the National Committee for Quality Assurance (NCQA).

**LifeSynch’s services include:**

- A network that includes individual providers, hospitals, and mental health and substance abuse programs. LifeSynch will give you the names of participating providers and programs near you.
- Inpatient hospitalization and outpatient treatment options, tailored to your needs.
- Clinical care management professionals who monitor treatment progress and the appropriateness of your care through regular communication with your treating doctors and other healthcare providers.
- Answers to your questions or concerns about your behavioral healthcare.

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**Getting Started**

To maximize your benefits and obtain behavioral health services covered by your health plan for yourself or a family member, call LifeSynch at Humana’s toll-free Customer Care number on the back of your Humana ID card. Be sure to select the behavioral health option. Our professionals will work with you to choose an appropriate mental health or substance abuse provider.

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**Please Note**

Participating primary care doctors, specialists, and other Humana network providers aren’t the agents, employees, or partners of Humana or any of our affiliates or subsidiaries. They’re independent contractors. Humana doesn’t provide medical services. Humana doesn’t endorse or control the clinical judgment or treatment recommendations made by the doctors or other providers listed in network directories or otherwise selected by you.

To be covered, expenses must be medically necessary and your healthcare plan must specify that they’re covered. Please read your Benefit Plan Document for more information about medical necessity and other coverage requirements.

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Offered by the Humana Family of Insurance and Health Plan Companies.

Our health benefit plans have limitations and exclusions.

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance) for more information on the company providing your benefits.
Humana.com
your link to smart choices

As a Humana member, you have powerful resources at your fingertips to help when you’re making decisions that affect your health.

At Humana.com, you can:
- Find in-network doctors, hospitals, and pharmacies near you
- Search Humana’s Drug List for prescription drugs and their estimated retail prices
- Visit the Drug Library to research prescription drugs
- Investigate possible lower-priced alternatives to your prescription drugs
- Find out about Humana’s health and wellness programs
- View and print a letter of coverage to give the doctor as proof of coverage

After you receive your Humana ID card, you can register for immediate access to MyHumana – your secure Website. At MyHumana, you can:
- View and print your Humana claims
- View and print your plan certificate and a summary of your plan benefits

- Visit Condition Centers to explore symptoms, treatments, and tests; track your condition; and print reports to discuss with your doctor
- Take a health assessment and print the results to share with your doctor
- Create your own health record, including family history, immunizations, allergies, and medications
- Order replacement ID cards
- Save money on medications, supplements, and other health and wellness products with the Savings Center
- Use Planning Tools to track your spending and estimate costs for a procedure or prescription

For more information, visit Humana.com. Click “Register” on the left side of the page and follow the instructions.

Health Plans are offered/administered by the Humana Family of Insurance and Health Plan Companies. Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance) for more information on the company providing your benefits. Our health plans have Limitations and Exclusions.
MyHumana Mobile allows you to...

» Check Member Information (ID card image coming soon)
» Locate Urgent Care Centers nearby
» Look up Spending Account balances
» Find Providers in your network
» View Medical Claims

MyHumana Mobile gives you three ways to access healthcare information via your cell phone!

1. Do you search the web on your phone?
   Log in at m.humana.com using your MyHumana User ID and Password.

2. Are you a Smartphone user?
   » iPhone users go to the Apple Store and search “Humana” to download the application.
   » Android users go to the Android Market and search “Humana” to download the application.
   » Blackberry Application coming soon!

3. Do you text?
   With Humana’s new text messaging it’s easy to check your spending account balance or have text messages sent to you.
   » Register or Log in to MyHumana
   » Go to My Profile
   » Click on “Manage My Mobile Number and Alerts”
   After you are enrolled text “BAL” to HUMANA (486262) to get account balances.
Know where to get care

What’s the right level of care?
How do you decide where to seek medical care for yourself or a family member? The right decision depends on your symptoms. Call HumanaFirst® Nurse Advice Line at 1-800-622-9529 for help in choosing the right level of care.

Also, remember your out-of-pocket costs can vary significantly by the place of service.

**Home Care**
Care at home is an important consideration. You can visit the Condition Centers in the Health & Wellness section of MyHumana, your secure website on Humana.com. You also can call HumanaFirst for self-care advice. In addition, a variety of books provide self-care guidelines.

**Doctor’s Office**
Your doctor should be your first call when you’re sick. Your doctor not only knows you, but has all of your medical records in one place. Because of this, he or she can make an informed decision about the care you need.

**Retail Clinic**
Put simply, these clinics make life easier when you need routine healthcare services for common illnesses – like colds, flu, or sore throats – as well as screenings and vaccinations. They usually cost less than an urgent care center or emergency room. Because they’re in grocery stores, drugstores, and other retailers, you won’t have to make multiple trips for medicine or supplies. Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs) generally provide care at these facilities.

**Urgent Care**
Go to an urgent care center when your doctor isn’t available. Infections, injuries, cuts, sprains, flu, fever, allergies, asthma, rash, and sore throat are some instances when you should consider going to an urgent care center instead of an emergency room. Urgent care centers have:

- Evening and weekend hours; usually a short wait
- Experienced, trained nurses and doctors
- Lower out-of-pocket costs for you than an emergency room

To find a location near you, go to Humana.com/members and click “Urgent Care Center” in the provider search box on the right side of the screen. You also can call HumanaFirst for assistance.

**Emergency Room**
Use the “ER” for emergencies only. If you’re facing a serious situation – like uncontrolled bleeding, chest pain, heart attack, difficulty breathing, possible stroke, or any threat to life or limb – head straight to the ER. But the emergency room is not an appropriate place to treat non-emergencies.

ERs aren’t “first come, first served.” Instead, a non-emergency must wait until all emergencies are seen. At the ER, you could face:

- A long wait, and a crowded waiting area
- A hefty bill with high out-of-pocket costs

Always be sure to check your plan details to confirm coverage.
Use Convenient Care Clinics to Save Time and Money!

What is a convenient care clinic?
It’s a retail-based clinic that treats common illnesses and offers health and wellness services. You don’t need an appointment. Convenient care clinics make a great option to emergency rooms or urgent care centers for common illnesses, screenings, or vaccinations.

How can a convenient care clinic benefit you?
They make life easier when you need routine healthcare services.
- You can get services outside doctor’s office hours – many are open seven days a week
- You can spend less out of pocket than you would at emergency rooms or urgent care centers
- You’ll probably have a shorter wait time

Where are they?
Convenient care clinics are usually in retail stores, supermarkets, and drugstores.

Who provides care at the clinics?
Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs) generally provide care at these facilities.
- ARNPs are registered nurses with special training for providing primary healthcare, including many tasks customarily performed by a doctor.
- PAs examine and treat patients, order and interpret laboratory tests and X-rays, and make diagnoses. They also treat minor injuries by suturing, splinting, and casting.

When would you use a convenient care clinics?
Examples of when to use convenient care clinics may be for:
- Common illnesses – allergy, bronchitis, common cold, ear infection, flu, sinus infection, sore throat, sprains, and strains
- Screenings – blood sugar testing, lipid panel, tuberculosis testing, pregnancy testing
- Vaccinations – seasonal flu, pneumonia, hepatitis A and B, tetanus, meningitis, chicken pox
- Physicals – routine annual checkups and sports, camp, work or school physicals

How do you find a convenient care clinic to use?
Search for clinics in your area on Humana.com/members.
- Select “Urgent Care Center” under the “Provider Search” box on the right side of the page
- Enter your member ID and your location
- Select “Convenient Care Clinic” under the “Choose Specialty” box and click “Search”
Emergency rooms treat serious or life-threatening conditions. For non-emergency conditions, it’s better to go to your doctor or an urgent care center.

When you can’t see your doctor right away, an urgent care center is a good medical and financial alternative to an emergency room.

Here’s why:

- Your wait will probably be shorter.
- Urgent care centers are often open evenings and weekends.
- You don’t need an appointment.
- An urgent care center may be closer to your home or workplace.
- Your cost is usually lower than it would be at an emergency room. In fact, if you go to an emergency room for non-emergency care, you may have to pay the entire bill yourself.

The choice is yours. But remember: For treatment of a minor illness or injury, an urgent care center can save you time and money.

To find an urgent care center near you, log on to Humana.com and:
- Click “find a doctor”
- Select “Urgent Care Centers” under Provider Search at the right of the page
- Use your member ID or ZIP code on the pop-up window to find an urgent care center near you
Healthcare can be a maze. Ever wish you had someone to help you find your way?

Personal Nurse®

Personal Nurse is a phone-based service, but it’s different from a nurse-on-call hotline. Specially-trained nurses reach out to those who may be at risk for, or currently dealing with, serious health issues. Participants work with the same nurse every time – a nurse who takes the time to understand your unique situation.
Personal Nurses provide education specific to your health. They also provide guidance about benefits, as well as pre- and post-hospitalization counseling, to help you fully understand your health benefit options and choices. Personal Nurses help you navigate the healthcare system, work better with your doctor, and make smart health decisions with confidence.

A Partnership for Better Health

What does a Personal Nurse do?
A Personal Nurse:

- **Offers information** – The nurse will help you identify health goals, explore treatment options with you, and guide you to resources so you can make informed decisions and take control of your health.

- **Develops a personal relationship** – You’ll be able to stay with your Personal Nurse as long as you remain a Humana member.

- **Collaborates with you** – The Personal Nurse service doesn’t replace your doctor. Instead, the nurse will help you communicate with your caregivers and work with your doctor so you can make decisions with confidence.

- **Provides a sounding board** – The Personal Nurse will help you gain control of your health – not just manage your symptoms. Sometimes having someone to talk to can mean the difference between you controlling a disease or it controlling you.

Working with your schedule
Personal Nurses work flexible hours, so the nurse can work with your schedule. During your phone calls, you will work with your nurse to decide future times you can talk. In addition, you’ll receive a welcome letter with your Personal Nurse’s business card and phone extension, so you can call your Personal Nurse as health concerns arise. All conversations are confidential.

You might be eligible for this program that helps you take charge of your health and fit healthy choices into your life – at no additional cost to you.

Registered nurses are available to help you get the most of Humana’s clinical guidance and support services. Call HumanaFirst® and select Nurse Advice, then Health Planning and Support:

1-800-622-9529
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](http://www.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.

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](http://www.humana.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.

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**HUMANA Discount Card**

SUBSCRIBER NAME: ____________________
SUBSCRIBER ID: ____________________
ANSI/BIN#: ____________________
VISION: EyeMed and TruVision
ALTERNATIVE MEDICINE: HWHN

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

Cut out this card and keep it in your wallet for handy reference.
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 RightSourceRxSM 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.
You want to get the most out of your health plan.

Here’s a good place to start.

One of the most important plan documents you’ll see is your Explanation of Benefits (EOB). It’s important to know that an EOB isn’t a bill. It’s simply a form you receive from Humana that explains the services and procedures you received, what they cost, and what – if anything – you owe.

Get familiar with just a few sections on this form and you’ll be well on your way to a better healthcare experience. Here’s what you need to know:

- **Patient information** shows which member of your health plan received care. All information on the EOB will refer to this person.

- **Servicing provider** tells you the doctor, dentist, or healthcare facility you visited.

- **Charge** lists the total amount the provider charged for services received.

- **Amount paid by Humana** shows the amount your plan pays for services received. In many cases, Humana has negotiated with providers to give you a discounted rate for certain services ... helping you save money.

- **Estimated member responsibility** tells you what you need to pay out-of-pocket. The provider will bill you for this amount. Examples include your deductible or coinsurance amount, any denied service amount, or any amount over the Maximum Allowable fee if you see a non-participating provider.

- **Remark codes** explain how your claim was processed or considered. You can find a description of the code on page 2, which provides details on this process.

- **Service code** is a number used in the healthcare business to process claims more efficiently. The Service code remarks section will tell you what this number means.

All information on your EOB should match the information that appears on statements you receive from your healthcare provider. If it doesn’t, contact your provider immediately.

**Keeping track**

Once you understand how to read your EOB, you’ll be better prepared to track expenses, understand your benefits, and avoid paying too much for your healthcare. It’s a good idea to keep your EOBs in a safe place should you have questions later. You always can view your past 18 months of EOBs anytime on MyHumana, your secure Website on Humana.com.
Quick and easy

If you’d like your EOBs as quickly as possible, you can view or download them online. Here’s what to do:

- Log in or register for MyHumana, your secure Website on Humana.com
- Select “Claims & Spending”
- Click “Claims” for a list of all your claims
- Select “Details” from the claim list
- Select “(PDF) Download Explanation of Benefits” to view or download your EOB

If you have questions, just give us a call at the number on the back of your Humana ID card or visit us online at Humana.com.
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 6 - 7 for details.

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SPECIAL ENROLLMENT NOTICE  This notice is being provided so that you understand your right to apply for group health insurance coverage outside of Pflugerville ISD open enrollment period. You should read this notice regardless of whether or not you are currently covered under Pflugerville ISD Group Health Plan. The Health Insurance Portability and Accountability Act (HIPAA) requires that employees be allowed to enroll themselves and/or their dependent(s) in an employer’s Group Health Plan under certain circumstances, described below, provided that the employee notifies the employer within 31 days of the following events:

- Loss of health coverage under another employer plan (including exhaustion of COBRA coverage);
- Acquiring a spouse through marriage; or
- Acquiring a dependent child through birth, adoption, placement for adoption or foster care placement.

Effective April 1, 2009, two new special enrollment rights were created under the Children’s Health Insurance Program Reauthorization Act of 2009. All group health plans must also permit employees and dependents, who are otherwise eligible for the group health plan, to enroll in the plan within 60 days of the following events:

- Losing eligibility for coverage under a State Medicaid or CHIP program; or
- Becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

PRE-EXISTING EXCLUSION  Pre-existing under the age of 19: Some group health plans restrict coverage for medical conditions present before an individual’s enrollment. These restrictions are known as “pre-existing condition exclusions.” Under the Patient Protection and Affordable Care Act a pre-existing exclusion may not be applied to any enrollee or dependent under the age of 19 for plan years beginning on or after September 23, 2010. Pre-existing condition exclusion in this instance means a limitation or exclusion of benefit (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Pre-existing age 19 and over: Under these circumstances a pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your “enrollment date”. Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 31 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use the certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.
NEWBORN ACT DISCLOSURE Under federal law, group health plans and health insurance issuers offering health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plan or issuers may not set the level of benefits or out-of-pocket costs so that the later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or the newborn than the earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your plan administrator.

WOMEN'S HEALTH & CANCER RIGHTS NOTICE As required by the Women’s Health and Cancer Rights Act of 1998 (WHCRA), this medical plan provides coverage for:

• All stages of reconstruction of the breast of which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance;
• Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information of WHCRA benefits, call your plan administrator.
Medicaid and the Children’s Health Insurance Program (CHIP)  
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility.

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<th>State</th>
<th>Program</th>
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<th>Phone (Out of State)</th>
<th>CHIP Website</th>
<th>Phone (Out of State)</th>
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<td>CALIFORNIA</td>
<td>Medicaid</td>
<td><a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a></td>
<td>1-866-298-8443</td>
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<td><a href="http://www.CHPplus.org">http://www.CHPplus.org</a></td>
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<tr>
<td>FLORIDA</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">http://www.fdhc.state.fl.us/Medicaid/index.shtml</a></td>
<td>1-877-357-3268</td>
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<tr>
<td>MISSOURI</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.html">http://www.dss.mo.gov/mhd/participants/pages/hipp.html</a></td>
<td>Phone: 573-751-2005</td>
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<td>MONTANA</td>
<td>Medicaid</td>
<td>Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a></td>
<td>1-800-694-3084</td>
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<td>INDIANA</td>
<td>Medicaid</td>
<td><a href="http://www.in.gov/fssa/">http://www.in.gov/fssa/</a></td>
<td>1-800-889-9948</td>
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<tr>
<td>IOWA</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a></td>
<td>1-888-346-9562</td>
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<td>KANSAS</td>
<td>Medicaid</td>
<td><a href="https://www.khpa.ks.gov">https://www.khpa.ks.gov</a></td>
<td>1-800-792-4884</td>
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<tr>
<td>KENTUCKY</td>
<td>Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>1-800-835-2570</td>
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<tr>
<td>LOUISIANA</td>
<td>Medicaid</td>
<td><a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a></td>
<td>1-888-342-6207</td>
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<td>MASSACHUSETTS</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
<td>1-800-462-1120</td>
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<td>MINNESOTA</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a></td>
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<tr>
<td>MASSACHUSETTS</td>
<td>Medicaid and CHIP</td>
<td>Click on Health Care, then Medical Assistance</td>
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<td>Phone (Outside of Twin City area):</td>
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<td>800-657-3739 Phone (Twin City area):</td>
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<td></td>
<td></td>
<td>651-431-2670</td>
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<tr>
<td>NEW YORK</td>
<td>Medicaid</td>
<td><a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
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<td>NORTH CAROLINA</td>
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<td><a href="http://www.nc.gov">http://www.nc.gov</a></td>
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<td>NORTH DAKOTA</td>
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<td><a href="http://www.nd.gov/dhs/services/services/medica">http://www.nd.gov/dhs/services/services/medica</a></td>
<td>1-800-755-2604</td>
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<td>NORTH DAKOTA</td>
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<td>OKLAHOMA</td>
<td>Medicaid</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
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<td>OREGON</td>
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<td><a href="http://www.oregon.gov/">http://www.oregon.gov/</a></td>
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<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td><a href="http://www.dpw.state.pa.us/partners/medicaid">http://www.dpw.state.pa.us/partners/medicaid</a></td>
<td>1-800-644-7730</td>
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<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td>assistance/doingbusiness/003670053.htm</td>
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<td>RHODE ISLAND</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.r.i.gov">http://www.dhs.r.i.gov</a></td>
<td>401-462-5300</td>
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<td>SOUTH CAROLINA</td>
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<td><a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
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<td>NEVADA</td>
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<td><a href="http://www.dhhs.nh.gov/ombp/index.htm">www.dhhs.nh.gov/ombp/index.htm</a></td>
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<td>NEW JERSEY</td>
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<td><a href="http://www.state.nm.us/humanservices/dm/">http://www.state.nm.us/humanservices/dm/</a></td>
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<td>TEXAS</td>
<td>Medicaid</td>
<td><a href="http://www.gethipptexas.com/">http://www.gethipptexas.com/</a></td>
<td>1-800-440-0493</td>
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<td>VERMONT</td>
<td>Medicaid</td>
<td><a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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<td></td>
<td></td>
<td>Telephone: 1-800-250-8427</td>
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<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a></td>
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<tr>
<td>WASHINGTON</td>
<td>Medicaid</td>
<td><a href="http://hrsa.dhs.wa.gov/premiumyml/Apply.shtm">http://hrsa.dhs.wa.gov/premiumyml/Apply.shtm</a></td>
<td>1-800-562-3022</td>
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<tr>
<td>WEST VIRGINIA</td>
<td>Medicaid</td>
<td><a href="http://www.wvrecovery.com/hipp.htm">http://www.wvrecovery.com/hipp.htm</a></td>
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<td></td>
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<td>Phone: 304-342-1604</td>
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To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)
Important Notice from Pflugerville ISD About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pflugerville ISD and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current Humana coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Pflugerville ISD has determined that the prescription drug coverage offered by Pflugerville ISD is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Pflugerville ISD coverage MAY be affected.

If you do decide to join a Medicare drug plan and drop your current Pflugerville ISD coverage, be aware that you and your dependents MAY be able to get this coverage back.
When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Pflugerville ISD and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pflugerville ISD changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).