

| OHIO 2012 Major Plan Benefits | | Plan pays for services provided by PARTICIPATING providers | Plan pays for services provided by NONPARTICIPATING providers |
|---|--|---|--|
| Preventive Care | <ul style="list-style-type: none"> Immunizations Mammogram and Pap smear Adult routine physical exam (<i>one per plan year</i>) Well-child care Well-woman exam | 100% | 60% after deductible |
| Physician Services | <ul style="list-style-type: none"> Office visits in conjunction with a sickness or injury Diagnostic tests, lab and X-rays (<i>when billed as an in-office procedure</i>) Allergy tests/serum Office surgery Physician visits to emergency room (1) Allergy injections Inpatient services Outpatient services Office therapy/chiropractic adjustment (<i>up to 12 visits per calendar year</i>) | 100% after \$20 copayment to primary care physician or \$40 copayment to specialist 100% 80% after deductible 100% after \$40 specialist copayment | 60% after deductible 60% after deductible 60% after deductible 60% after deductible |
| Hospital Services | <ul style="list-style-type: none"> Inpatient care (<i>semiprivate room and ancillary services</i>) Outpatient surgery Outpatient nonsurgical care Emergency room | 80% after deductible 100% after \$150 copayment (<i>waived if admitted</i>) (1) | 70% after applicable copayment 100% after \$150 copayment (<i>waived if admitted</i>) (1) |
| Prescription Drugs | <ul style="list-style-type: none"> Retail pharmacy (Rx4) (<i>30-day supply</i>) Mail order (Rx4) (<i>90-day supply</i>) | 100% after: Level One – \$10 copayment Level Two – \$30 copayment Level Three – \$50 copayment Level Four – 25% 100% after: Level One – \$20 copayment Level Two – \$60 copayment Level Three – \$100 copayment Level Four – 25% | 70% after applicable copayment Not covered |
| Other Medical Services | <ul style="list-style-type: none"> Skilled nursing facility (<i>up to 120 days per plan year</i>) (2) Home health care (<i>up to 30 visits per plan year</i>) (2) Durable medical equipment (2) Hospice services (2) Physical and occupational therapy (<i>up to 60 visits per calendar year</i>) Speech therapy (<i>up to 20 visits per calendar year</i>) Urgent care facility | 80% after deductible 100% 100% after \$20 copayment 100% after \$20 copayment 100% after \$35 copayment | 60% after deductible 60% after deductible 60% after deductible 60% after deductible |
| Deductible | <ul style="list-style-type: none"> Individual Family | \$750 \$1,500 | \$1,500 \$3,000 |
| Maximum Out-Of-Pocket Expense Limit <i>(excludes deductible)</i> | <ul style="list-style-type: none"> Individual Family | \$2,000 \$4,000 | \$4,000 \$8,000 |
| Lifetime Maximum Benefit | <ul style="list-style-type: none"> Per member benefit paid by plan | | Unlimited |
| Behavioral Health <i>(mental health and substance abuse services)</i> | <ul style="list-style-type: none"> Inpatient-covered services Outpatient and office therapy-covered services | 80% after deductible 100% after a \$40 copayment per visit | 60% after deductible 60% after deductible |

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/](https://www.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 - Plan pays benefits based on maximum allowable fees as defined in your Certificate. Participating providers agree to accept maximum allowable fees, as listed in negotiated payment schedules, as payment in full.

For services rendered by nonparticipating physicians, the member is responsible for charges exceeding a fee schedule selected by your employer and defined in your Summary Plan Description. For services from other nonparticipating providers, the member is responsible for amounts which exceed maximum allowable fees, as defined in your Summary Plan Description.

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) 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.
- (2) Failure to preauthorize may result in denial of payment.

For general questions about the plan, contact your Human Resources office.

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This is a brief plan description. It is not the plan document and does not include all of the benefits, limitations and exclusions of the plan. More complete terms of the plan are contained in the Summary Plan Description.