# HumanaPPO

Summary of Benefits

| ARCHDIOCESE OF LOUISVILLE | CoverageFirst | Plan pays for services provided by ***PARTICIPATING*** providers | Plan pays for services provided by ***NONPARTICIPATING*** providers |
|---|---|---|---|
| **Up-front Benefit Allowance** | • Annual member *benefit (Applies to medical services received from participating providers only. Does not apply to member copayments.)* | $500 per calendar year per member | Not applicable |
| **Annual Deductible** *(copayments do not apply)* | • Individual | $1,000 | $3,000 |
| | • Family | $3,000 | $9,000 |
| **Preventive Care** | • Annual routine adult physical examinations *(16 years and above)*<br>• Routine child care *(up to age 16)* | **100%** after $25 copayment per visit to primary care physician or $40 copayment per visit to specialist (1) | **70%** after deductible |
| | • Routine immunizations *(up to age 18)*<br>• Routine mammography and Pap smears<br>• Routine outpatient laboratory tests/X-rays | **80%** after deductible | **60%** after deductible |
| **Physician Services** | • Office visits *(excludes diagnostic lab and X-ray)*<br>• Prenatal benefit *(office visit copayment applies to first visit only)*<br>• Allergy testing *(covered as part of office visit)* | **100%** after $25 copayment per visit to primary care physician or $40 copayment per visit to specialist (1) | **70%** after deductible |
| | • Diagnostic tests, lab and X-rays *(when done in office by physician)*<br>• Allergy serum<br>• Inpatient services<br>• Outpatient services *(includes surgery)*<br>• Physician visits to emergency room | **80%** after deductible | **60%** after deductible |
| | • Allergy injections | **100%** after $5 copayment per visit | **70%** after deductible |
| **Hospital Services** | • Inpatient care *(semiprivate room and board, nursing care, ICU)* | **80%** after $100 copayment per day for first five days per admission, and after deductible | **60%** after $100 copayment per day for first five days per admission, and after deductible |
| | • Outpatient nonsurgical care | **80%** after deductible | **60%** after deductible |
| | • Outpatient surgery | **80%** after $100 copayment per visit after deductible | **60%** after $100 copayment per visit after deductible |
| | • Emergency room visit *(copayment is waived if admitted)* (2) | **80%** after $150 copayment | **60%** after $150 copayment *(paid at participating level for emergency medical condition)* |
| **Prescription Drugs** | • Retail *(30-day supply)* | **100%** after:<br>Level One – $10 copayment<br>Level Two – $25 copayment<br>Level Three – $50 copayment<br>Level Four – **25%** copayment<br>*(up to $2,500 maximum out-of-pocket per calendar year)* | Not covered |
| | • Mail order *(90-day supply)* | **100%** after two times the applicable copayment | Not covered |
| **Other Medical Services** | • Skilled nursing facility *(up to 60 days per calendar year)*<br>• Home health care *(up to 100 visits per calendar year)*<br>• Durable medical equipment<br>• Physical, speech and hearing therapy | **80%** after deductible | **60%** after deductible |
| | • Ambulance (2) | **80%** after deductible | **60%** after deductible *(paid at participating level for emergency medical condition)* |
| | • Chiropractic *(as medically necessary) 20 visits per calendar year* | **100%** after $40 copayment per visit | **70%** after deductible |

**CoverageFirst combines the cost-saving incentives of a modern health plan with freedom of choice and an annual benefit allowance. When you see participating providers, you receive the highest level of benefits available under your plan. At the same time, you retain the flexibility to see any physician.**

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|---|---|---|---|
| **Behavioral Health** *(mental health and substance abuse services)* | • Inpatient<br>• Outpatient | Same as any other covered condition | Same as any other covered condition |
| **Maximum Out-Of-Pocket Expense Limit** *(excludes deductibles and copayments)* | • Individual | $2,000 | $6,000 |
| | • Family | $6,000 | $18,000 |
| **Lifetime Maximum Benefit** | | | $5,000,000 |

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

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

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

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

**Participating primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement 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 Certificate for more information on medical necessity and other specific plan benefits.**

(1) Copayments for visits to primary care physicians, as defined in the plan, are generally lower than for visits to specialists. The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician or internist.
(2) Services for an emergency medical condition provided by a nonparticipating provider will be covered at the participating provider level.
(3) This represents an annual limit on the amount of covered expenses subject to coinsurance. There is a separate annual coinsurance limit for participating and nonparticipating benefits.
(4) Your out-of-pocket expenses will never exceed nonparticipating provider limits.
(5) Contact CorpHealth at 1-800-659-0349.

**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.**

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

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

**PRE-EXISTING CONDITION EXCLUSION**

If the plan imposes a pre-existing condition exclusion, and you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy; genetic information in the absence of a diagnosis of the condition related to the information; or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

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

HUMANA®
*Guidance* when you need it most

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Offered by Humana Health Plan, Inc.