

HumanaPPO

Summary of Benefits

ARCHDIOCESE OF LOUISVILLE

Humana 500

Plan pays for services provided by **PARTICIPATING** providers

Plan pays for services provided by **NONPARTICIPATING** providers

		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 (to age 18) Mammogram and Pap smears 	100%	60% after deductible
	<ul style="list-style-type: none"> Well-child care (to age 16) Adult routine physical exam (one per calendar year) 	100% after \$25 copayment per visit	60% after deductible
Physician Services	<ul style="list-style-type: none"> Office visits (excluding routine X-ray, lab and pathology) Chiropractic care (up to 12 visits) 	100% after \$25 copayment per visit to primary care physician or \$40 copayment per visit to specialist (See notes.) (1)	60% after deductible
	<ul style="list-style-type: none"> Diagnostic tests, lab and X-rays Allergy injections and serum 	100%	60% after deductible
	<ul style="list-style-type: none"> Inpatient services Outpatient services Physician visits to emergency room 	80% after deductible	60% after deductible
Hospital Services	<ul style="list-style-type: none"> Inpatient care (semiprivate room and board, nursing care, ICU) 	100% after \$150 copayment per day for the first five days per admission, and after deductible	60% after deductible
	<ul style="list-style-type: none"> Diagnostic tests, lab and X-rays Outpatient nonsurgical care Ancillary services 	80% after deductible	60% after deductible
	<ul style="list-style-type: none"> Outpatient surgery 	100% after \$100 copayment per visit, and after deductible	60% after deductible
	<ul style="list-style-type: none"> Emergency room (waived if admitted) 	80% after \$150 copayment per visit	60% after \$150 copayment per visit (paid at participating level for emergency medical condition) (2)
	<ul style="list-style-type: none"> Urgent care facility 	100% after \$35 copayment per visit	60% after \$75 copayment per visit
Prescription Drugs	<ul style="list-style-type: none"> Retail (30-day supply) 	100% after: Level One – \$15 copayment Level Two – \$30 copayment Level Three – \$55 copayment Level Four – 25% copayment (up to \$2,500 maximum out-of-pocket per calendar year)	Not covered
	<ul style="list-style-type: none"> Mail order (90-day supply) 	100% after two times the applicable copayment	Not covered
Other Medical Services	<ul style="list-style-type: none"> Home health care (up to 100 visits per calendar year) Skilled nursing facility (up to 30 days per calendar year) Durable medical equipment 	80% after deductible	60% after deductible
	<ul style="list-style-type: none"> Short term physical, occupational and speech therapy (up to 20 visits) 	100% after \$25 copayment per visit	60% after \$25 copayment per visit
	<ul style="list-style-type: none"> Ambulance (2) 	100%	100%
Out-Of-Pocket Amounts (includes all copayments and deductibles except prescription drugs)	<ul style="list-style-type: none"> Annual deductible 	\$500 per member \$1,000 per family	\$1,000 per member \$2,000 per family
	<ul style="list-style-type: none"> Annual coinsurance limit (3) – Individual 	\$2,500	\$4,000 (4)
	<ul style="list-style-type: none"> – Family 	\$5,000	\$8,000 (4)

HumanaPPO combines the cost-saving incentives of a modern health plan with freedom of choice. 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.

<p>Behavioral Health <i>(mental health and substance abuse services)</i> (5)</p>	<ul style="list-style-type: none"> • Inpatient • Outpatient and office therapy 	<p>Same as any other illness</p>	<p>Same as any other illness</p>
<p>Lifetime Maximum Benefit</p>		<p>\$5,000,000</p>	

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.

