

	PPO 500	
<b>Preauthorization Requirements</b> Preauthorization is required in order to receive coverage for certain services and supplies. Please visit our website at <a href="http://www.humana.com/members/home.asp">www.humana.com/members/home.asp</a> or call customer service for the most up-to-date list. Failure to obtain necessary preauthorization when required, may result in a reduction of otherwise payable benefits.		
<b>Penalty:</b> 50% after any applicable deductible and copayments for items appearing on the pre-authorization list. Prior to 1/1/07 - only non emergent admissions for mental health & chemical dependency services & Serious Mental Illness; Transplant services and DME >\$750 in cost will have the penalty applied.		
	<b>PAR Benefit</b>	<b>NON-PAR Benefit</b>
<b>DEDUCTIBLES/ LIFETIME MAX (Par and Non-Par Deductibles and MOOP's do not cross reduce) (Copays do not apply to maximum out-of-pocket expense limit) (Deductibles do not apply toward OOP Max Limit)</b>		
Annual Deductible (Per Calendar Year*** Plan Year)		
Single	\$500	\$1,000
Family	\$1,500	\$3,000
<b>Maximum Out-of-Pocket (or use Copayment limit)</b>		
Single	\$3,000	\$6,000
Family	\$9,000	\$18,000
Lifetime Maximum Benefit	\$5,000,000	
<b>HOSPITAL SERVICES</b>		
Inpatient Care	Days 1-5 adm: \$250 Copay/Day , then Par Deductible. Once deductible is satisfied, \$250 copay then 100%. Days 6 and after: 100% after par ded	70% after Nonpar Ded
Outpatient Surgery - Facility	\$100 Copay per visit then deductible. Once ded is satisfied, \$100 copay plus 100%	70% after Nonpar Ded
Outpatient Tests, Lab, X-Rays, Therapies (Non-Surgical)	80% after Par Ded	50% after Nonpar Ded
Pre-admission Tests	80% after Par Ded	50% after Nonpar Ded
Second Surgical Opinion	80% after Par Ded	50% after Nonpar Ded
Hospital Emergency Services ***	\$150 Copay per visit then deductible. Once ded is satisfied \$150 copay plus 100%	70% after Nonpar Ded
<b>PHYSICIAN SERVICES</b>		
Office Visits (incl. Diag. Lab/X-ray) (Excl. Outpt. Surgery)(Prenatal care, OV copay applies to first visit only)	100% after \$25 Copay/Visit	70% after Nonpar Ded
Office Visits-Specialty (incl. Diag. Lab/X-ray) (Excl. Outpt. Surgery)(Prenatal care, OV copay applies to first visit only)	100% after \$40 Copay Per Visit	70% after Nonpar Ded
Allergy Testing	Covered as part of Office Visit Copayment	70% after Nonpar Ded
Allergy Serum	80% after Par Ded	50% after Nonpar Ded
Allergy Injections	100% after \$5 Copay/Visit	70% after Nonpar Ded
Emergency Room Services***	80% after Par Ded	50% after Nonpar Ded
Inpatient	80% after Par Ded	50% after Nonpar Ded
<b>CHILD diagnostic follow-up care related to hearing impairment from birth through the date the child is 24 months old (see mandate for specifics)</b>		
Outpatient (incl. Surgery)	100% after \$25 Copay/Visit 80% after Par Ded	70% after Nonpar Ded 50% after Nonpar Ded

	PPO 500	
<b>ADDITIONAL MEDICAL SERVICES</b>		
Home Health Care (100 visits per calendar year*** Plan Year MTV)	80% after Par Ded	50% after Nonpar Ded
Durable Medical Equipment	80% after Par Ded	50% after Nonpar Ded
Skilled Nursing Facility (60 Days Per Calendar Year*** Plan Year MTV)	80% after Par Ded	50% after Nonpar Ded
Private Duty Nursing (Inpatient Hospital Only)	80% after Par Ded	50% after Nonpar Ded
Physical, Speech, Hearing Therapy	80% after Par Ded	50% after Nonpar Ded
Ambulance (Par benefits paid if true medical emergency) ***	80% after Par Ded	50% after Nonpar Ded
Urgent Care facility -	100% after \$40 Copay Per Visit	70% after Nonpar Ded
Transplant Services* Note: All direct non-medical costs are limited to \$10,000 per transplant and temporary lodging is limited to \$75/day.	100% after Par Ded	70% after Nonpar Ded
<b>MENTAL DISORDERS **</b>		
Inpatient Services	Days 1-5 adm: \$250 Copay/Day , then 100% Days 6 and after: 100%	70% after Nonpar Ded
Inpatient Professional Services	80%	50%
Maximum Inpatient Covered Days	30 Days/Cal Yr***Plan Year	
Outpatient Individual Therapy Session	100% after \$40 Copay Per Visit	70%
Outpatient Group Therapy Session	100% after \$25 Copay Per Visit	70%
Outpatient Maximum Visits	30 Visits/Cal Yr ***Plan Year	
Residential Treatment Center (limited to one half day of inpatient care for mental disorders)	Days 1-5 adm: \$250 Copay/Day, then 100% Days 6 and after: 100%	70% after Nonpar Ded
<b>CHEMICAL AND ALCOHOL DEPENDENCY</b>		
Inpatient Services	Same as any other covered condition	Same as any other covered condition
Inpatient Professional Services	Same as any other covered condition	Same as any other covered condition
Outpatient Therapy Session	100% after \$40 Copay Per Visit	70% after Nonpar Ded
Residential Treatment Center	Same as any other covered condition	Same as any other covered condition
<b>SERIOUS MENTAL ILLNESS</b>		
Inpatient Services	Same as any other covered condition	Same as any other covered condition
Maximum Inpatient Covered Days	45 Days/Cal Yr***Plan Year	
Outpatient Care	100% after \$40 Copay Per Visit	70% after Nonpar Ded
Outpatient Maximum Visits	60 Visit/Cal Yr***Plan Year	
Residential Treatment Center (limited to one half day of inpatient care for serious mental illness)	Same as any other covered condition	Same as any other covered condition
<b>HOSPICE SERVICES</b>		
Inpatient	80% after Par Ded	50% after Nonpar Ded
Outpatient	80% after Par Ded	50% after Nonpar Ded
<b>PREVENTIVE DEDUCTIBLE RIDER</b>		
Routine Immunizations (birth to age 7)	100%	100%
Routine Immunizations (age 7 to 18)	100%	70% after Nonpar Ded
Routine Child Care (to age 16) includes lab and x-ray	Same as OV Copayment	70% after Nonpar Ded
Routine Pap Smear	100%	70% after Nonpar Ded
Routine Mammogram	100%	70% after Nonpar Ded
Routine Adult Physical Exam (16 yrs and above; excludes lab and X-ray)	Same as OV Copayment	70% after Nonpar Ded
<i>CHILD routine hearing screening; birth thru date child is 30 days old (no deductible may apply)</i>	100%	70%
Routine Lab Test & X-Ray Associated with Adult Routine Physical Exam	100%	70% after Nonpar Ded

	PPO 500	
<b>PHARMACY BENEFIT</b>		
Pharmacy Benefit has both Par and Non-Par Benefits. Par Pharmacies must be used for the highest level of benefits.		
Tier 1	\$10 Copay	Copay + 30%
Tier 2	\$20 Copay	Copay + 30%
Tier 3	\$40 Copay	Copay + 30%
Tier 4	25% Copay up to \$2500 MOOP Per Calendar Year	Copay + 30%
Mail Order	2 X	
*Transplant services do not apply toward the Maximum Out-of-Pocket Expense Limit		
**Any out-of-pocket expenses for the treatment of Mental Disorders do not apply toward the annual out-of-pocket expense limit.		

	PPO 500	
<b>Riders</b>		
Spinal Manipulation - 100% of the spinal manipulation services up to \$25 (we pay the first \$25 of the negotiated rate) - up to 20 visits/year. This coverage does not reduce OOP. It is available for Par/NonPar providers and does not cover the initial evaluation.		
Vision Riders: 447		
<b>Mammogram Frequency Limitations:</b>		
Annually for all insured females age 35 and older same as any other radiological exam.		
<b>Preauthorization requirements :</b>		
Preauthorization is required by us for durable medical equipment and diabetes equipment with charges in excess of \$750 per item.		
Inpatient Mental Disorders, SMI, Chemical and Alcohol dependency, organ transplant benefit.		
<b>Mandates:</b>		
<b>Coinsurance Level</b> - cannot vary coinsurance level by more than 30% in and out of plan		
<b>Residential Treatment Center</b> - policies that cover treatment for mental/emotional disorders must also include coverage that is no less favorable for treatment in a residential treatment center for children/adolescents		
<b>Serious Mental Illness</b> - requires that serious mental illness be covered the same as any other disease to a maximum of 45 days inpatient and 60 visits outpatient per calendar year for groups 51+. This benefit must be provided to municipalities, counties, school districts or other political subdivisions of the state, regardless of size, same as any other disease, with no limits		
<b>Alcoholism</b> - must be covered the same as any other disease		
<b>Chemical Dependency</b> - must be provided the same as any other disease		
<b>Osteoporosis</b> - must cover bone mass measurement for detection of osteoporosis		
<b>Prostate</b> - must allow an annual exam for detection of prostate cancer		
<b>Immunizations</b> - must cover childhood immunizations at 100% from birth to age 6		
<b>Phenylketonuria</b> - must cover formulas necessary for treatment of phenylketonuria to same extent as other drugs		
<b>Breast Reconstruction</b> - if plan covers mastectomies, breast reconstruction must also be covered		
<b>Routine Hearing/Children</b> - requires coverage of hearing impairment screening tests and necessary diagnostic follow up care for children		
<b>Birth Control</b> - coverage is mandated for contraceptive prescriptive drugs and devices and outpatient services		
<b>Emergency Room</b> - must allow emergency care services at the PPO level of benefits until the insured can reasonably be expected to transfer to a PPO provider/facility		
<b>Brain Trauma</b> - coverage is mandated for treatment of an acquired brain injury		
<b>Home Health Care</b> - cannot provide less than 60 visits/cal year. Coinsurance and deductible must be same as any other hospital service		

	PPO 500	
<b>TMJ</b> - if policy provides benefits for medically necessary diagnostic or surgical treatment of skeletal joints must include comparable benefits for TMJ		
<b>Diabetes</b> - requires coverage for equipment and supplies used to treat diabetes		
<b>Craniofacial Abnormalities</b> - mandates benefits for reconstructive surgery of craniofacial abnormalities for a child under the age of 18 years		
<b>Dependent Coverage</b> - eligible dependents must be covered until age 25 regardless of student status (this includes eligible grandchildren)		
<b>Complications of Pregnancy</b> - Covered same as any other illness.		
<b>Colorectal Cancer Screening</b> - Must provide benefits for screening medical procedures for each person who is 50 years or older. Must have the choice of at least one of the following: (1) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every 5 years or (2) a colonoscopy performed every 10 years		
<b>Telemedicine</b> - policy may not exclude a telemedicine medical service or a telehealth service		
<b>HIV, AIDS, or HIV related illnesses</b> - May not exclude or deny coverage.		
<b>Psychiatric Day Treatment</b> - must provide benefits for a mental illness in a psychiatric day treatment facility (one half day of treatment in a hospital equals one full day of treatment in a psychiatric day treatment facility)		