HumanaHMO Summary of Benefits

Premier, Select and Advantage Plans

CHICAGO Plan 2, Option 80

		Plan pays for services provided or arranged by your ***PARTICIPATING*** primary care physician
Preventive Care	• Routine physical exam • Well-child care • Well-woman services *(annual mammogram, routine Pap smear)* (2) • Well-men care *(annual PSA test and prostate exam)*	**100%** after a $20 copayment per visit
Physician Services *(Most visits to specialists must be authorized by a primary care physician)*	• Office visits • Diagnostic lab testing and X-rays • Allergy testing • Allergy serums and injections • Surgery performed in a physician's office	**100%** after a $20 copayment per visit
	• Emergency room visits	**100%**
Hospital Services	• Inpatient care *(semiprivate room and ancillary services, physician visits)* • Preadmission testing • Outpatient nonsurgical care • Emergency care *(emergency room, emergency services)*	**100%**
	• Outpatient hospital care *(outpatient surgery and medically necessary services and supplies)*	**100%** after a $20 copayment per visit
Prescription Drugs	• Please see attached prescription benefit information, if applicable.	
Other Medical Services	• Short term physical, speech and occupational therapy *(primary care physician must determine member's condition can improve significantly within two months)* (1) • Skilled nursing facility *(up to 120 days per calendar year)* (1) • Hospice services *(outpatient to $2,000 per calendar year maximum)* (1) • Home health care (1) • Durable medical equipment (1)	**100%**
Illinois Mental Health Services	• Inpatient facility *(up to 30 days per calendar year)* (3) • Outpatient *(up to 20 visits per calendar year)* (4)	**100%**
Indiana Mental Health Services	• Inpatient facility • Outpatient	**100%**
Illinois Alcoholism and Chemical Dependency Services	• Inpatient facility *(up to 30 days per calendar year)* (3) • Outpatient *(up to 20 visits per calendar year)* (4)	**100%**
Indiana Alcoholism and Chemical Dependency Services	• Inpatient facility • Outpatient	**100%**
Copayment Limit	• Individual	$1,500
	• Family	$3,000

HumanaHMO is a health plan that enables you to take advantage of care arranged by the primary care physician you select from the network of participating providers. Your personal physician provides your primary care, referring you to specialists when appropriate.

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Most medical services must be provided or arranged by your participating primary care physician. Only emergency services are covered when provided by nonparticipating providers or facilities, or when received outside the plan service area.

Participating primary care and specialists physicians and other providers in Humana's network 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) Failure to preauthorize may result in financial penalty or denial of payment.
(2) No copayment is required for annual mammogram unless in conjunction with an office visit.
(3) Care in a day hospital, residential nonhospital or intensive outpatient mode may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by the primary care physician.
(4) Group outpatient visits may be substituted on a two-to-one basis for individual outpatient visits as deemed appropriate by the plan's mental health provider.

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

Limitations and Exclusions

This list is a summary of limitations and exclusions. Please check your Certificate of Coverage for complete detailed description of all exclusions and limitations. The Certificate of Coverage is the document upon which benefit payment and coverage will be determined.

Unless specifically stated otherwise, no coverage will be provided for or on account of:

1. Care for conditions that state or local law requires to be treated in a public facility.
2. Experimental drugs or substances not approved by us or by the Food and Drug Administration; drugs or substances used for other than Food and Drug Administration approved indications or drugs labeled: "Caution - limited by federal law to investigational use."
3. Drugs or medicines, prescription or nonprescription, provided to the member while he or she is not hospital confined, unless otherwise covered by a Prescription Drug Benefit Rider attached to the Group Plan.
4. Any service, supply, care or treatment that is not described in the Health Services Agreement or any rider attached to and made a part of the Group Plan.
5. Any service, supply, care or treatment provided to the member without the authorization of his or her primary care physician, unless the member is receiving emergency services or care from a participating woman's principal health care provider who is in the same medical group as the member's primary care physician.
6. The purchase or fitting of hearing aids, eyeglasses, contact lenses or advice on their care; except the first pair of eyeglasses or contacts needed due to cataract surgery or an accident.
7. Biomicroscopy, field charting or aniseikonic investigation.
8. Reversal of elective sterilization or sexual reassignment surgery.
9. Any drug, biological product, device, medical treatment or procedure which is experimental or investigational, as described in the Group Plan.
10. Plastic, cosmetic or reconstructive surgery, except as specified in the Group Plan.
11. Services and supplies for dental care, including dental appliances; treatment of the teeth or periodontium or oral surgery, except as described in the Group Plan.
12. Services and supplies for treatment of temporomandibular joint (TMJ) syndrome/dysfunction unless such services are medically necessary as determined by the member's primary care physician and authorized on a prospective and timely basis by the HMO's medical director.
13. Care and treatment of the feet including arch supports unless such services are medically necessary as determined by the member's primary care physician.
14. A physical examination which would result in a duplication of benefits.
15. Any service, supply or treatment connected with custodial care.
16. Any treatment to reduce obesity including, but not limited to, surgical procedures, unless medically necessary.

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