

Plan pays for services at **PARTICIPATING** providers

<b>Preventive Care</b>	<ul style="list-style-type: none"> <li>Routine immunizations (except for foreign travel)</li> <li>Mammogram</li> </ul>	<b>100%</b>	
	<ul style="list-style-type: none"> <li>Routine physical exam</li> <li>Well-child care</li> <li>Well-woman exam (may self-refer to OB/GYN)</li> <li>Vision exam (one eye exam per year)</li> </ul>	<b>100%</b> after \$20 copayment per visit to primary care physician (including OB/GYN) or \$35 copayment per visit to specialist  <b>100%</b> after \$35 copayment per visit	
<b>Physician Services</b>	<ul style="list-style-type: none"> <li>Office visits (office visits in conjunction with an illness or injury)</li> <li>Prenatal care (office visit copayment applies to first visit only)</li> <li>Allergy tests</li> </ul>	<b>100%</b> after \$20 copayment per visit to primary care physician (including OB/GYN) or \$35 copayment per visit to specialist	
	<ul style="list-style-type: none"> <li>Allergy injections</li> <li>Emergency room visits</li> <li>Allergy serum</li> </ul>	<b>100%</b>	
<b>Hospital Services</b>	<ul style="list-style-type: none"> <li>Inpatient care (semiprivate room, ancillary services, physician visits)</li> </ul>	<b>100%</b> after \$500 copayment per admission	
	<ul style="list-style-type: none"> <li>Outpatient surgical care (includes ambulatory surgical center)</li> </ul>	<b>100%</b> after \$50 copayment per visit	
	<ul style="list-style-type: none"> <li>Outpatient nonsurgical care</li> </ul>	<b>100%</b>	
	<ul style="list-style-type: none"> <li>Emergency care (emergency room, emergency services)</li> </ul>	<b>100%</b> after \$75 copayment per visit (copayment is waived if admitted)	
<b>Other Medical Services</b>	<ul style="list-style-type: none"> <li>Skilled nursing facility (up to 120 days per calendar year)</li> <li>Home health care (up to 100 visits per calendar year)</li> <li>Bone density testing for women age 35 and older</li> <li>Durable medical equipment</li> <li>Hospice services (1)</li> </ul>	<b>100%</b>	
	<ul style="list-style-type: none"> <li>Ambulance</li> </ul>	<b>100%</b> after \$50 copayment per use	
	<ul style="list-style-type: none"> <li>Physical and occupational therapy (up to 50 visits combined per calendar year)</li> <li>Chiropractic care (up to 30 visits per calendar year)</li> <li>Speech therapy (up to 25 visits per calendar year)</li> </ul>	<b>100%</b> after \$35 copayment per visit	
	<ul style="list-style-type: none"> <li>Diabetes services</li> <li>– Diabetes education</li> </ul>	<b>100%</b> after \$20 copayment per visit to primary care physician or \$35 copayment per visit to specialist	
	<ul style="list-style-type: none"> <li>– Diabetes equipment</li> </ul>	<b>100%</b>	
	<ul style="list-style-type: none"> <li>– Diabetes supplies (30-day supply per copayment)</li> </ul>	Subject to the applicable prescription drug copayment.	
	<b>Maximum Out-of-Pocket Expense Limit</b> (per calendar year)	<ul style="list-style-type: none"> <li>Individual</li> </ul>	\$2,000
		<ul style="list-style-type: none"> <li>Family</li> </ul>	\$4,000
<b>Lifetime Maximum Benefit</b>		\$5,000,000	
<b>Behavioral Health</b> (mental health and substance abuse services)	<ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient and office therapy</li> </ul>	Same as any other covered condition	

**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. Only emergency services, or urgent services received while out of the service area, are covered when provided by nonparticipating providers or facilities.

**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 Summary Plan Description for more information on medical necessity and other specific plan benefits.**

- (1) Pursuant to state regulation, the hospice benefit provides coverage which is at least equal to the Medicare benefit.

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

**HUMANA**<sup>®</sup>  
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