Humana CoverageFirst℠ PPO Summary of Benefits

St. Camillus Health Care

WISCONSIN	Humana CoverageFirst PPO 08 100/70 Plan	Plan pays for services at ***PARTICIPATING*** providers	Plan pays for services at ***NONPARTICIPATING*** providers
Up-front Benefit Allowance	• Annual member *benefit (Applies to medical services received from participating providers only. Preventive and pharmacy do not apply. Does not apply to member copayments.)*	$500 per calendar year per member	Not applicable
Annual Deductible *(per calendar year; copayments do not apply)*	• Individual	$2,500	Two times indivdual participating deductible
	• Family (1)	Three times indivdual participating deductible	Two times family participating deductible
Preventive Care *(Does not reduce the benefit allowance)*	• Annual routine adult physical exam *(18 years and above)* (2) • Routine child care *(up to age 18)*	**100%** after office visit copayment	**70%** after deductible
	• Routine immunizations (*up to age 18)* • Routine mammography and Pap smears • Routine outpatient laboratory tests/X-rays	**100%**	**70%** after deductible
	• Preventive endoscopy *(includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy)*	**100%**	**70%** after deductible
Physician Services (2)	• Office visits (*excludes diagnostic lab and X-ray)* • Prenatal benefit *(office visit copayment applies to first visit only)* • Allergy testing *(covered as part of office visit)*	**100%** after $25 primary care physician/ $40 specialist copayment per visit	**70%** after deductible
	• Physician visits to emergency room (3)	**100%**	**100%**
	• Diagnostic tests, lab and X-rays *(when performed in office or clinic)* • Allergy serum	**100%**	**70%** after deductible
	• Inpatient services • Outpatient services	**100%** after deductible	**70%** after deductible
	• Allergy injections and nonroutine injections other than allergy	**100%** after $5 copayment per visit	**70%** after deductible
Hospital Services	• Inpatient care *(semiprivate room and board, nursing care, ICU)*	**100%** after $100 copayment per day for five days plus participating deductible	**70%** after deductible
	• Outpatient surgery	**100%** after $100 copayment per visit	**70%** after deductible
	• Outpatient nonsurgical care	**100%** after deductible	**70%** after deductible
	• Emergency room visit *(copayment is waived if admitted)* (3)	**100%** after $150 copayment per visit	**100%** after $150 copayment per visit
Prescription Drugs	• Please see attached pharmacy benefit information, if applicable		
Other Medical Services (4)	• Skilled nursing facility ***(up to 60 days per SM*** • Home health care ***(up to 60 visits per calendar year)*** • Durable medical equipment ***(unlimited)***	**100%** after deductible	**70%** after deductible
	• Physical, occupational, cognitive, speech and audiology therapy ***(unlimited)***		
	• Ambulance (3)	**100%** after deductible	**100%** after participating deductible
	• Chiropractic	Same as specialist copayment	**70%** after deductible

Humana 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.

	Humana CoverageFirst PPO 08 100/70 Plan	Plan pays for services at ***PARTICIPATING*** providers	Plan pays for services at ***NONPARTICIPATING*** providers
Other Medical Services (4) *(continued)*	• Transplant services	Same as any other covered condition when services are received from a Humana Transplant Network provider.	Same as any other covered condition *(covered expenses are limited to a maximum benefit of $35,000 per transplant)*
	• Kidney disease *(up to $30,000 per calendar year)*	Same as any other illness	Same as any other illness
Behavioral Health *(mental health and substance abuse services)* (4)	• Inpatient services *(limited to 30 days per calendar year)*	Same as any other covered condition	Same as any other covered condition
	• Outpatient therapy sessions *(limited to 20 visits per calendar year)*	Same as specialist copayment	**70%** after deductible
Maximum Out-Of-Pocket Expense Limit *(per calendar year; excludes deductibles and copayments)*	• Individual	N/A	$4,000
	• Family	N/A	Three times individual nonparticipating maximum out-of-pocket
Lifetime Maximum Benefit	$5,000,000 *(participating and nonparticipating combined)*		

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.

Limited Coverage Notice

PREFERRED PROVIDER PLAN NOTICE TO ENROLLEES IMPORTANT NOTICE

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED.

You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered service, benefit payment to such nonparticipating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Nonparticipating providers pay bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill.

You are strongly encouraged to contact us to verify the status of the providers involved in your care including, for example, the anesthesiologist, radiologist, pathologist, facility, clinic or laboratory, when scheduling appointments or elective procedures to determine whether each provider is a participating or nonparticipating provider. Such information may assist in your selection of provider(s) and will likely affect the level of copayment, deductible and amount of coinsurance applicable to the care you receive. The information contained in this directory may change during your plan year. Please contact 1-866-427-7478 to learn more about the participating providers in your network and the implications, including financial, if you decide to receive your care from nonparticipating providers.

Participating primary care and specialist physicians and other providers in Humana's networks are <u>not</u> 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) You are not required to meet individual deductibles once the family deductible has been met.
(2) 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.
(3) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.
(4) Visit and day limits are combined for participating and nonparticipating providers.

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. This guide is available at Humana.com/members/enrollment center/ pre-enrollment disclosures or through your sales representative.

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 benefits administrator.

Limitations and Exclusions

The plan imposes a pre-existing condition exclusion. This means that if 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 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.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Humana Enrollment at 2432 Fortune Drive, Lexington, KY 40509 or 1-800-872-7207.

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

1. Treatments, services, supplies or surgeries that are not medically necessary, except for the specified routine preventive services as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of the certificate.
2. A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit.
3. A sickness or bodily injury, which is covered under any Workers' Compensation or similar law. This limitation also applies to a covered person who is not covered by Workers' Compensation and lawfully chose not to be.
4. Any drug, biological product, device, medical treatment, or procedure which is experimental, or investigational or for research purposes.
5. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.
6. Prescription drugs and self-administered injectable drugs, unless administered to you:
   - While an inpatient in a hospital, skilled nursing facility, or health care treatment facility;
   - By a health care practitioner during an office visit; or
   - By a home health care agency as part of a covered home health care plan when approved by us.
7. Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.
8. In-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; infertility services; sex change services; or reversal of elective sterilization.
9. Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
   - Resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or
   - Resulting from congenital disease or anomaly of a covered dependent child, which resulted in a functional impairment.
     A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Expense incurred for reconstructive surgery performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met.
10. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery or periodontic surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a bodily injury or sickness unless otherwise stated in the certificate.
11. Custodial care and maintenance care.
12. Any treatment, including but not limited to surgical procedures:
    - For obesity, which includes morbid obesity; or
    - For obesity, which includes morbid obesity, for the purpose of treating a sickness or bodily injury caused by, complicated by, or exacerbated by the obesity.
13. Alternative medicine.
14. Vision examinations or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error; or, the purchase or fitting of eyeglasses or contact lenses (except as the result of an accident or following cataract surgery as stated in the certificate).
15. Expenses for treatment of complications of non-covered procedures or services.

These limitations and exclusions 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 the procedure, treatment or supply; however, the procedure, treatment or supply will not be a covered expense.