12

City of West Allis
Matter Summary

7525 W. Greenfield Ave.
West Allis, WI 53214

File Number	Title	Status
R-2003-0262	Resolution	In Committee

Resolution approving the Agreement for the PPO Medical Plan Change Document for 2004.

Introduced: 9/16/2003

Controlling Body: Administration & Finance Committee

COMMITTEE RECOMMENDATION adopt

ACTION DATE:	MOVER	SECONDER		AYE	NO	PRESENT	EXCUSED
			Barczak	✓			
			Czaplewski	✓			
			Kopplin	✓			
9-16-03	✓		Lajsic	✓			
			Narlock				
			Reinke	✓			
			Sengstock				
			Trudell				
			Vitale				
			Weigel				
			TOTAL	5	—		

SIGNATURE OF COMMITTEE MEMBER (RECORDER)

Chair _____ Vice-Chair _____ Member _____

COMMON COUNCIL ACTION adopt

ACTION DATE:	MOVER	SECONDER		AYE	NO	PRESENT	EXCUSED
			Barczak	✓			
	✓		Czaplewski	✓			
			Kopplin	✓			
9-16-03			Lajsic	✓			
			Narlock	✓			
		✓	Reinke	✓			
			Sengstock	✓			
			Trudell	✓			
			Vitale	✓			
			Weigel	✓			
			TOTAL	10	—		

Personnel Admin

COMMITTEES OF THE WEST ALLIS COMMON COUNCIL
2003

ADMINISTRATION AND FINANCE
Chair: Alderperson Czaplewski
V.C.: Alderperson Kopplin
Alderpersons: Barczak
Lajsic
Reinke

ADVISORY
Chair: Alderperson Reinke
V.C.: Alderperson Vitale
Alderpersons: Kopplin
Lajsic
Narlock

LICENSE AND HEALTH
Chair: Alderperson Barczak
V.C.: Alderperson Sengstock
Alderpersons: Kopplin
Trudell
Vitale

SAFETY AND DEVELOPMENT
Chair: Alderperson Lajsic
V.C.: Alderperson Weigel
Alderpersons: Czaplewski
Narlock
Reinke

PUBLIC WORKS
Chair: Alderperson Narlock
V.C.: Alderperson Trudell
Alderpersons: Sengstock
Weigel
Vitale

City of West Allis

Resolution

7525 W. Greenfield Ave.
West Allis, WI 53214

File Number: R-2003-0262

Final Action: 9-16-03

Resolution authorizing the Agreement for the PPO Medical Plan Change Document for 2004.

WHEREAS, it is necessary to annually approve the Agreement for the PPO Medical Plan Change Document; and,

NOW, THEREFORE, BE IT RESOLVED by the Common Council of the City of West Allis that the Agreement for the PPO Medical Plan Change Document for 2004 is hereby approved

BE IT FURTHER RESOLVED by the Common Council of the City of West Allis that the proper City Officials are authorized and directed to execute said Agreement on behalf of the City.

ADM\ORDRES\ADMR235

ADOPTED September 16, 2003

Paul M. Ziehler

Paul M. Ziehler, CAO/Clerk/Treasurer

APPROVED September 22, 2003

Jeannette Bell

Jeannette Bell, Mayor

CLAIMS PAYMENT AGREEMENT
PPO Medical PLAN CHANGE DOCUMENT

This authorization and agreement is made and entered into by City of West Allis and Humana Insurance Company ("HIC"), effective January 1, 2004 and March 1, 2004.

This authorization and agreement concerns the establishment and development of a contractual relationship between HIC and the Client for providing administrative services with respect to the City of West Allis Health Benefit Plan (the "Plan").

The Client and HIC agree as follows:

a- The **PLAN CHANGE DOCUMENT** will be used to build the Plan(s) for administration, including benefits, assembly of the summary plan description(s) and future reference.

b- HIC is authorized and is granted the right to process and make payment on claims submitted by Participants in the Plan, on their behalf and on behalf of their covered dependents, for benefits under the Plan during the period prior to the delivery, via electronic and/or printed copy method, to the Client and HIC of a final Summary Plan Description.

c- Claims payment will be based on benefits and provisions described and stated in the **PLAN CHANGE DOCUMENT** and/or other written documents provided by the Client describing the Plan, including the Prior Summary Plan Description.

d- If benefit levels or provisions change in future drafts or modifications of the **PLAN CHANGE DOCUMENT** and/or the documents selected above, HIC shall not be required to reprocess claims properly processed under the agreed-upon description of the Plan as of the time that the claims were processed.

e- Between the time successor drafts of the **PLAN CHANGE DOCUMENT** are prepared and exchanged, any changes to the documents describing the Plan for these purposes must be in writing, state the effective date, and must be timely communicated to and accepted for claims administration by HIC. Changes made in this fashion will be incorporated into the documents controlling claims processing and payment, as described and agreed to under this agreement.

The Client and HIC have caused this agreement to be executed by their respective officers or representatives as duly authorized.

THE CLIENT
By: [signature], CAO/Clerk Tr.
Date: 9/25/03

HUMANA INSURANCE COMPANY
By: [signature: Thomas Klammer]
Thomas P. Klammer
Director of Self-Funded Solutions

PLAN CHANGE DOCUMENT

CITY OF WEST ALLIS

Effective Date:
January 1, 2004 & March 1, 2004

Group Number(s)

Effective: 1-1-2004
3954742, 3954744 & 3954759

Effective: 3-1-2004
3954754, 3954760 & 3954761

Product Number(s)
01/6892/01

AGENT INFORMATION
Name: Dan Aschenbrenner - Frank Haack Agency
Address: P.O. Box 26997
Milwaukee, WI 53226-0997
Phone: 414-259-8859
Fax: 414-475-0559
Email: danaschenbrenner@haack.com

CLAIMS PAYMENT AGREEMENT
PPO Medical PLAN CHANGE DOCUMENT

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THE CLIENT

By: _____

Date: _____

HUMANA INSURANCE COMPANY

By: _____

Thomas P. Klammer

Director of Self-Funded Solutions

REINSURANCE INFORMATION:

1. Reinsurance Carrier: (Please send completed stop loss application and/or policy)
   ___X___ Humana
   _____ Other than Humana (please send completed stop loss application and/or policy)

   NOTE: Complete remaining questions for Outside Reinsurance carrier only.

   Name: _____
   Address: _____
   _____
   Contact Name: _____
   Telephone: _____

2. Type of stop loss coverage's applied for:
   _____ Aggregate
   ___X___ Specific (Deductible Amount) $175,000

3. Is Humana responsible for providing information to a third party? N/A
   _____ No
   _____ Yes

   If Yes: _____ Group
   _____ Broker
   _____ Reinsurance Carrier

   NOTE: If it is Humana's responsibility to provide reinsurance information to a third party, please provide a copy of the reinsurance contract for use in establishing the notification process.

4. What is the early notification point to external reinsurer of a potential large claims? N/A

5. Are there any special filing requirements? N/A
   _____ No
   _____ Yes, specify; _____

6. Will Humana be made aware of anyone who has an active reinsurance claim? N/A
   _____ No
   _____ Yes

7. Reinsurance carrier plan year? March 1

8. Contract is:

   ___X___ Incurred — Humana Carrier #: 999 Treaty #: 0002; Outside Carrier #: _____ Treaty #: _____

   _____ Incurred/Paid (paid in system) — Humana Carrier #: 999 Treaty #: 0002; Outside Carrier #: _____ Treaty #: _____

   ___X___ 12/12 _____ 12/15 _____ 12/18 _____ Other

City of West Allis
Effective: January 1, 2004

UTILIZATION/CASE MANAGEMENT

1 Please indicate the services that are subject to pre-certification:

	Service Requires Pre-Cert (yes/no)	Penalty Taken When Pre-Cert Not Completed
INPATIENT HOSPITAL	YES	Benefit payable at 50%
INPATIENT MENTAL DISORDER ALCOHOLISM AND CHEMICAL DEPENDENCY	YES	Benefit payable at 50%
** OUTPATIENT MENTAL DISORDER, ALCOHOLISM, AND CHEMICAL DEPENDENCY	NO	n/a
OUTPATIENT SURGERY	NO	n/a
SKILLED NURSERY FACILITY	YES	Benefit payable at 50%
HOSPICE CARE	YES	Benefit payable at 50%
HOME HEALTH CARE	YES	Benefit payable at 50%

2 Penalty amount applies to:

X Qualified practitioner & hospital charges

____ Hospital charges only

3 Does penalty apply to the out-of-pocket maximum?

____ Yes

X No

4 Criteria for non-emergency hospital admissions:

X 7 days

____ Other, Specify:

5 Criteria for emergency hospital admissions:

X 48 hours

____ Other, Specify:

CASE MANAGEMENT

6 Case Management will be done by:

X Humana, Inc.

____ Outside firm

7 Indicate the name, address, and telephone number of outside review firm if other than precertification agency:

Company Name: _____

Contact Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

8 What services are the outsidie review agency responsible for?

DISEASE MANAGEMENT:

1. Humana Beginnings:
   X No
   ___ Yes, Does a penalty apply if not utilized?
   ___ No
   ___ Yes

2. Humana First:
   (Steerage is only available for clients accessing Humana Proprietary, ChoiceCare, PPOM or Touchpoint Preferred)
   X No
   ___ Yes

   *** If another network is included, steerage will not be available for any network.**

3. Disease Management Package:
   X No
   ___ Yes

CorSolutions	Coronary Artery Disease
	Congestive Heart Failure
RMS	End Stage Renal (Only offered in the following states: **CA, NV, AZ, TX, KS, MO, IL, WI, IN, OH, KY, FL, NJ)**
Accordant	Rare Diseases
PAIDOS	Neonatal Program (Only offered in the following Markets: **Chicago, Kansas, Louisville, Milwaukee, Austin, Tampa)**

4. Humana For Your Benefit. (Quarterly publication mailed directly to members. Additional admin fee applies)
   ___ Yes
   X No

NETWORK INFORMATION:

1. Network HCN

2. Vendors Shared Savings? (Access fee = 30% of savings billed back to client)
   X Yes
   ___ No

MEDICAL BENEFITS - GENERAL INFORMATION

1. Type of Plan:
   - ____ Comparable to prior plan
   - X PPO Plan
   - ____ Other, specify; ____

2. Lifetime Maximum:
   - X $1,000,000
   - ____ $2,000,000
   - ____ Other ____

3. Lifetime Maximum applies to:
   - ____ Basic Expenses
   - ____ Major Medical Expenses
   - X All Expenses - NON PAR ONLY

4. Deductible:
   A. Plan deductible applies to:
   X Par ____ X Non-Par

   B. $0 Individual $ Amount Par $200 Individual $ Amount Non Par

   C. Family Unit Limit:
   $0 $ Per fmly aggregate Par $600 $ Per fmly aggregate Non Par
   ____ Calendar year X Plan year (date) 1-Mar

   D. Last thee month carry over credit?
   ____ No X Yes

   E. Common Accident provision?
   ____ No X Yes

   2 OR MORE # of family members?

5. How is coinsurance accumulated?
   - ____ Covered/Combined (Option 1)
   - X Out-of-Pocket/Combined (Option 3)
   - ____ Out-of-Pocket Not to Exceed Out-of-Plan, Out-of-Pocket (Option 9)

6. Coinsurance / Out-of-Pocket Information:

Option 3 - OUT-OF-POCKET / COMBINED
(Note: Deductibles will track on a combined basis)

A. 100% Par Coinsurance (Individual) 80% Non-Par Coinsurance (Individual)

B.

Par out-of-pocket limits		Non-Par out-of-pocket limits
0	$ Individual	$1,500 $ Individual
0	$ Family	$3,000 $ Family

C. Are there any services which do not apply to the out-of-pocket limits?
   - X Penalties
   - X Copayments
   - ____ Psch/Alch/Chem maximums
   - ____ Other, specify ____

D. Is the individual deductible for Par and Non-Par included in the out-of-pocket limits?
_____ No
__X__ Yes

E. Is the family deductible for Par and Non-Par included in the out-of-pocket limits?
_____ No
__X__ Yes

7. Office visit copayment:
__X__ $10.00 - TO A MAX OF 5 COPAYS PER PERSON PER PLAN YEAR
_____ $15.00
_____ $20.00
_____ Other

8. If a predetermination of medical benefits is submitted in writing, how long is it valid for?
__X__ 180 days
_____ Other, specify; _____

9. Proof of loss period:
__X__ 15 months
_____ Other, specify; _____

10. Maximum allowable fee (surgical) - **pertains to Non-Par only:**
_____ 75th percentile (0175)
_____ 80th percentile (080)
__X__ 85th percentile (085)
_____ 90th percentile (090)

10a. Maximum allowable fee (surgical) variance dollar amount (flex amount:
_____ $10.00 __N/A__ Other, specify: _____

10b. Maximum allowable fee (surgical) variance percentage:
_____ 5% __N/A__ Other, specify: _____

10c. Do we allow the greater or lessor of both the dollar amount and the percentage?
_____ Greater _____ Lessor __X__ Not applicable

11. Maximum allowable fee (non-surgical) - **pertains to Non-Par only:**
_____ 75th percentile (0175)
_____ 80th percentile (080)
__X__ 85th percentile (085)
_____ 90th percentile (090)

11a. Maximum allowable fee (surgical) variance dollar amount (flex amount:
_____ $5.00 __N/A__ Other, specify: _____

11b. Maximum allowable fee (surgical) variance percentage:
_____ 5% __N/A__ Other, specify: _____

11c. Do we allow the greater or lessor of both the dollar amount and the percentage?
_____ Greater _____ Lessor __X__ Not applicable

12. If a service is not covered under the Plan are related services covered?
__X__ No _____ Yes, specify; _____

13. If a complication arises as a result of a serivde not covered under the Plan, are services related to the complication covered?

_____ No ___X___ Yes, specify; _____

14. Medical coordination of benefits provision:
___X___ Normal liability _____ 100%

14a. If 100% is selected, should a reserve be created? N/A
_____ No _____ Yes

14b. ___X___ Birthday Rule _____ Male / Female

14c. Are expenses covered under both medical and dental to be coordinated?
_____ No
___X___ Yes
___X___ Medical Primary
_____ Dental Primary

15. Medicare coordination of benefits provision:
___X___ Normal Liability _____ 100%

16. Does the Plan exclude custodial care?
_____ No ___X___ Yes

17. Does the Plan exclude services which are not medically necessary?
_____ No ___X___ Yes

18. Does the Plan exclude experimental and investigational treatment?
_____ No ___X___ Yes

19. Will the Plan pay any applicable tax in states which require taxation of medical services?
_____ No ___X___ Yes

20. Is this group currently registered with the State of New York (NYS) for surcharge reporting?

___X___ Yes, the group is registered as a self-funded employer group - *if Group has another TPA other than Humana they must complete 2.6 (chg of TPA) and send copy to Humana*

_____ Yes, are they a monthly or annual payer
_____ Monthly
X _____ Annual

_____ Yes, group has been self-reporting to NYS - *If Humnana to handle, form 2.6 (chg of TPA) must be completed by Group*

_____ No, the group is currently self-funded, but has not registered with the State of New York - *Group must complete forms 2.0 - (election form), 2.1 - (product info), 2.2 - (covered lives) and 2.3 - (apportionment)*

_____ No, the group has declined the option of registering with the State of New York
No election = 25% surcharge / penalty versus election = 8.18%

(Variable: Use if group is rolling from fully-insured) N/A

_____ Yes, the group is currently FI going to ASO - G *roup must complete 2.5 (chg of status FI>ASO or ASO>FI and copy HUM)*

_____ No, the group is currently fully insured and rolling to self-funded - *Group must complete forms 2.0 - (election form), 2.1 - (product info), 2.2 - (covered lives) and 2.3 - (apportionment)*

_____ No, the group has declined the option of registering with the State of new York

No election = 25% surcharge / penalty versus election = 8.18%

20a. On the date of administration is effective with HUMANA:

X Group requests that HUMANA file the periodic reports and remit any amounts owed to NYS (preferred option)
If the prior carrier has been reporting, the group completes 2.6 for New York, and provides copy to Humana. Humana completes 2.4a for New York, Humana will prepare report and remit to NYS any monies owed for any claim and/or population liability. Humana will then bill the group for the amount paid to NYS.

_____ Humana to report and pay only when liability is encountered (no election w/NYS = 24%)

_____ Group perfers to **self-file** NYS reports
(Note: This option requires Humana Management approval. It is more efficient for Humana to administer internally since both population and claim liability must be reported. This avoids additional administration involved in sending reports to a group)

21. Date prior carrier will cease paying claims: N/A _____

22. Humana, Inc. will pay the Massachuesetts state surcharge tax (3% assessed to acute care hospitals or ambulatory surgical centers) automatically when services are rendered in Massachuesetts and will bill the employer monthly for the amount o a separate bill.

AUDIT OF BILL

1. Who will administer this program?
   X Humana, Inc
   _____ Employer
   _____ Will not administer

2. What benefits will this provision apply to?
   _____ Inpatient Hospital only
   _____ Qualified Practitioner only
   X All Medicql Services
   _____ Dental Services

3. Specify benefit:
   _____ 50% of $1,000 ($500 paid)
   X Other, specify; $500 PD PER OCCURANCE @ 25%

   _____ Per calendary year
   X Per occurrence

	QUALIFIED PRACTITIONER SERVICES	Par Benefit	Non-Par Benefit
1	Supplemental Accident Benefit	N/A	N/A
	Must treatment begin within specified time period?	N/A	
	Do all services apply to this benefit?	N/A	
2	Office visits other than Routine:	$10 Copay/100% (to max of 5 per person/per plan year)	Deductible/80%/100%
3	Durable Medical Equipment & Supplies:	100%	Deductible/80%/100%
4	Is there coverage for infusion pumps for treatment	YES	
	of diabetes? (If yes, specify limitations)	30 Days used prior to purchase (or) 1 Per calendar year	
5	Injections, other than routine	100%	Deductible/80%/100%
6	Vials	100%	Deductible/80%/100%
7	Prescription Drugs:		
	A. Brand Name Drugs	N/C @ PHA, 100% ALL OTHER POS	N/C @ PHA, Ded/80%/100% all other pos
	B. Generic Drugs	N/C @ PHA, 100% ALL OTHER POS	N/C @ PHA, Ded/80%/100% all other pos
	C. Smoking Cessation Products (Patches/Drugs)	NOT COVERED	NOT COVERED
	Note: If Smoking Cessation Products are covered, do you allow any other services?		N/A
	D. Pre-Natal Vitamins (until delivery date)	N/C @ PHA, 100% ALL OTHER POS	N/C @ PHA, Ded/80%/100% all other pos
	E. HIV - Phase III Investigational Drugs	N/C @ PHA, 100% ALL OTHER POS	N/C @ PHA, Ded/80%/100% all other pos
8	Routine Child Care		
	Maximums:		
	* No Maximum	N/A	N/A
	* Dollar Maximum	N/A	N/A
	Paid/Covered	N/A	N/A
	* Calendar Year Maximum	N/A	N/A
	* Lifetime Maximum	N/A	N/A
	* Through / To age	N/A	
	* In-Plan /Out-of-Plan aggregate to same maximum?	N/A	
8a.	Routine Child Exam	$10 Copay/100% (to max of 5 per person/per plan year)	NOT COVERED
	Routine Child Lab/Xray	100%	NOT COVERED
	Routine Child Child Immunizations	100%	NOT COVERED
9	Routine Adult Care		
	* No Maximum	N/A	N/A
	* Dollar Maximum	N/A	N/A
	Paid/Covered	N/A	N/A
	* Calendar Year Maximum	N/A	N/A
	* Lifetime Maximum	N/A	N/A
	* In-Plan /Out-of-Plan aggregate to same maximum?	N/A	
9a.	Routine Adult Exam	$10 Copay/100% (to max of 5 per person/per plan year)	NOT COVERED
	Routine Adult Lab / Xray	100%	NOT COVERED

	Routine Mammogram	100%	Deductible/80%100%
	Routine Mammogram Frequency:	NO FREQUENCY	SEE BELOW
X	* 2 examinations by low-dose for a female covered person age 45-49: an annual exam by low-dose mammography for a female		
	covered person age 50 and over.		YES
	* Other		N/A
	* No frequency		N/A
	Does frequency indicated apply to both par and non-par benefits?		N/A
	Routine Pap Smears	100%	Deductible/80%/100%
	Routine Pap smears frequency:		
	* 1 per calendar year		N/A
	* Other		N/A
	* No frequency		YES
	Does frequency indicated apply to both par and non-par benefits?		N/A
	Routine Adult Immunizations	100%	NOT COVERED
10	Prostrate Antigen Testing	100%	NOT COVERED
11	Routine Vision		
	* Not covered	N/A	NOT COVERED
	* Dollar Maximum	N/A	N/A
	* Visit Maximum	1 PER PLAN YEAR%	NOT COVERED
	* In-Plan / Out-of-Plan aggregate towards same maximum?		N/A
	Routine Vision Exam	$10 Copay/100% (to max of 5 per person/per plan year)	NOT COVERED
	Routine Vision Refraction	100%	NOT COVERED
	Routine Vision Tonometry	100%	NOT COVERED
	Lenses/Glasses and Contacts: (Indicate Dollar Maximum / Paid / Covered / Per Single Lens / Per Pair)		
	* Single	NOT COVERED	NOT COVERED
	* Bifocal	NOT COVERED	NOT COVERED
	* Trifocal	NOT COVERED	NOT COVERED
	* Lenticular	NOT COVERED	NOT COVERED
	* Contacts (Non-Disposable)	NOT COVERED	NOT COVERED
	* Contacts (Disposable)	NOT COVERED	NOT COVERED
	* Frames	NOT COVERED	NOT COVERED
	Is there coverage for repair of frames, lenses, contacts, etc.?		NO
	If there is coverage for contacts and lenses, are both allowed during the same time period?		NO
12	Routine Hearing		
	* Not covered	N/A	NOT COVERED
	* Dollar Maximum	N/A	N/A
	* Visit Maximum (calendar/plan/lifetime)	N/A	N/A
	* In-Plan / Out-of-Plan aggregate towards same maximum?		N/A
	Routine Hearing Exam	$10 Copay/100% (to max of 5 per person/per plan year)	NOT COVERED
	Routine Hearing Testing	100%	NOT COVERED
	Routine Hearing Aids	NOT COVERED	NOT COVERED
	Is there coverage for the repair, maintenance/supplies of hearing aids?		NO
13	Chiropractic Care		
	* Not covered	N/A	N/A
	* Dollar Maximum	N/A	N/A
	* Visit Maximum (calendar/plan/lifetime)	N/A	N/A

	* In-Plan / Out-of-Plan aggregate towards same maximum?		N/A
	Chiropractic Exam(s)	$10 Copay/100% (to max of 5 per person/per plan year)	Deductible/80%/100%
	Chiropractic X-ray / Lab	100%	100%
	Chiropractic Manipulations	100%	Deductible/80%/100%
	Chiropractic Therapy	100%	Deductible/80%/100%
	Chiropractic Routine Maintenance Care	NOT COVERED	NOT COVERED
14	Diagnostic X-ray / Lab	100%	100%
15	Pre-Admission Testing	100%	100%
16	Anesthesia	100%	Deductible/80%/100%
17	Surgery / Surgeon	100%	Deductible/80%/100%
18	Surgery / Assistant Surgeon	100%	Deductible/80%/100%
	* Allowance: 20% of primary surgeon's U&C	YES	
19	Surgery / Physician Assistant	100%	Deductible/80%/100%
	* Allowance: 10% of primary surgeon's U&C	YES	
20	Surgical Supplies	100%	Deductible/80%/100%
21	Multiple Surgical Procedures	100%	Deductible/80%/100%
22	Second Surgical Opinion	100%	100%
	* Required		
	* Does a penalty apply if not obtained?	N/A	
	* Not Required		
23	Maternity (Normal, C-Section, Complications)	SAAOD	SAAOD
	* If billed separately per visit / exam, does exam copay apply?		No
24	Dependent Daughter Maternity		
	* All Maternity	SAAOD	SAAOD
	* Complication Only	SAAOD	SAAOD
25	Newborn		
	* Is deductibe waived for well-baby services?	YES	
	Well Newborn	100%	80%/100%
	Sick Newborn	100%	Deductible/80%/100%
26	Family Planning		
	* Birth Control Pills	100%	Deductible/80%/100%
	* Birth Control Devices	100%	Deductible/80%/100%
	* Contraceptive Injections	100%	Deductible/80%/100%
	* Contraceptive Implant Systems	100%	Deductible/80%/100%
	* How is removal covered?	100%	Deductible/80%/100%
27	Sterilization (Clinic / All Others)		
	* Reversal of Sterilization	100%	Not Covered

28	Abortions		
	* Elective	NOT COVERED	NOT COVERED
	* Applies to (All covered females / EE spouse only)	N/A	
	* Life Threatening	100%	Deductible/80%/100%
	* Applies to (All covered females / EE spouse only)	YES	

	INPATIENT SERVICES:	Par Benefit	Non-Par Benefit
1	Inpatient Deductible	N/A	N/A
	(ie: None / $ per admission / other)		
2	New Period of confinement begins after:	N/A	
3	If a patient is admitted on an emergency basis to an out-of-plan hospital, which benefits apply?		Par / Non Par
	Type of Service - Facility		
4	Room and Board	100%	Deductible/80%/100%
5	Ancillary Services	100%	Deductible/80%/100%
	Type of Service - Qualified Practitioner		
6	In-Hospital Physician Visits	100%	Deductible/80%/100%
7	Radiology	100%	100%
8	Pathology	100%	100%
9	Anesthesia	100%	Deductible/80%/100%
	Radiology, pathology, anesthesia and emergency room physician services rendered by a Non-PPO physician, but		
	performed at a PPO facility are automatically paid at the in-plan level of benefits.		
	Professional fees received associated with computer automated Radiology and Pathology services are standardly		
	processed under the primary lab and xray fees. This service is automated, with no manual intervention necessary. If		
	a separate professional fee is billed, it is not considered an elibigle expense and would be denied.		

	OUTPATIENT SERVICES:	Par Benefit	Non-Par Benefit
1	Are all services for outpatient care payable regardless if it is a true emergency?		YES
2	Emergency Room Copay:	$25	
3	If the Plan has an emergency room copay, is it waived if admitted?		YES
4	If emergency services are received from an out-of-plan hospital, which benefits apply?		Par
	Type of Service - Facility		
5	Emergency Room	$25 COPAY/100%	$25 COPAY/100%
6	Emergency Sickness	$25 COPAY/100%	$25 COPAY/100%
7	Bodily Injury	$25 COPAY/100%	$25 COPAY/100%
8	Ancillary Services (other than Room & Physician)	100%	Deductible/80%/100%
	Type of Service - Qualified Practitioner		
9	Emergency Room Physician	100%	Deductible/80%/100%
10	Radiology	100%	100%
			100%
11	Pathology	100%	Deductible/80%/100%
12	Anesthesia	100%	Deductible/80%/100%
	Radiology, pathology, anesthesia and emergency room physician services rendered by a Non-PPO physician, but		
	performed at a PPO facility are automatically paid at the in-plan level of benefits.		
	Professional fees received associated with computer automated Radiology and Pathology services are standardly		
	processed under the primary lab and xray fees. This service is automated, with no manual intervention necessary. If		
	a separate professional fee is billed, it is not considered an elibigle expense and would be denied.		
	Type of Service - Miscellaneous		
11	Free Standing Surgical Center	100%	Deductible/80%/100%
12	Birthing Centers	100%	Deductible/80%/100%

	MISCELLANEOUS SERVICES:	Par Benefit	Non-Par Benefit
1	Skilled Nursing Facility	100%	Deductible/80%/100%
	- Limitation	30 days per confinement	
	- What constitutes a separate period of confinement? **180 days**		
2	Home Health Care	100%	Deductible/80%/100%
	- Limitations?	40 visits per plan year	
3	Hospice	100%	Deductible/80%/100%
4	Bereavement	Not Covered	Not Covered
5	Therapies		
	Are all places of service paid the same?	Yes	
	* Speech Therapy	100%	Deductible/80%/100%
	* Physical Therapy	100%	Deductible/80%/100%
	* Occupational Therapy	100%	Deductible/80%/100%
	* Respiratory Therapy	100%	Deductible/80%/100%
	* Vision Therapy	100%	Deductible/80%/100%
	* Chemotherapy	100%	Deductible/80%/100%
	* Radiation Therapy	100%	Deductible/80%/100%
	* Cardiac Rehabilitation (limited to phase I & II)	100%	Deductible/80%/100%
6	Morbid Obesity	Not Covered	Not Covered
7	Ambulance **(Note: Currently there are no ambulance providers in the PPO Network(s).**		
	* Ground	100%	100%
	* Air	100%	100%
8	Temporomandibular Joint Dysfunction (TMJ)	100%	Deductible/80%/100%
	* Not Covered	N/A	N/A
	* Dollar Maximum	$1,250	$1,250
	* Paid / Covered	PAID	PAID
	* Calendar Year / Plan Year / Lifetime	PLAN YEAR	PLAN YEAR
	* TMJ Splints / Appliances	100%	Deductible/80%/100%
9	Oral Surgeries	100%	Deductible/80%/100%
	Check all services below that are to be covered:		
	* Excision of partially or completely unerupted impacted teeth;		X
	* Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof/floor of the mouth when such conditions require pathological examination;		X
	* Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;		X
	* Reduction of fractures and dislocation of the jaw;		X
	* External incision and drainage of cellulitis;		X
	* Incision of accessory sinuses, salivary glands or ducts;		X
	* Frenectomy (the cutting of the tissue in the midline of the tongue);		X
	* Periodontal Surgeries (Osseous & Gingivectomy;		X
	* Other(s) specify: apicoectomy, excision of exostoses, alveolectomy, frenectomy, removal retained residual root, gingival curettage, apicl curettage		X

10	Dental Osteotomies	NOT COVERED	NOT COVERED
11	Dental Implants	NOT COVERED	NOT COVERED
12	Routine Dental Extractions	NOT COVERED	NOT COVERED
13	Dental Injuries	100%	100%
	* Initial extraction of the teeth due to injury is covered.		Yes
	* Replacement of natural teeth due to injury is covered.		Yes
	* Dental services other than extraction/replacement of teeth are covered if due to an injury.		Yes
	* Treatment must begin within 90 days of injury to be covered by the Plan.		Yes
	* Treatment must be completed within 12 months after injury to be covered by the Plan.		Yes
	* Coverage for teeth injured as a result of chewing is NOT a covered service.		Yes
	* Benefits will be paid only for expenses incurred for the least expensive service.		Yes
14	Infertility Counseling and Treatment	100%	NOT COVERED
	* Not Covered		NOT COVERED
	* Not Covered, unless due to underlying medical condition (ie. diabetes, prostate cancer)		NOT COVERED
	* Processed under normal Plan benefits, not subject to medical necessity;		NOT COVERED
	* Other, please specify; **$2000 PD PER LIFETIME FOR PAR PROVIDERS**		NOT COVERED
15	Artificial means of achieving pregnancy	100% TO $2000 PD LFT MAX	NOT COVERED
16	Organ Transplants	100%	NOT COVERED
	Kidney	100% to $30,000 pd pln yr max	100% to $30,000 pd pln yr max
17	Treatment or Diagnosis of Sexual Dysfunction / Impotence		
	* Not Covered		N/A
	* Not Covered, unless due to underlying medical condition (ie. diabetes, prostate cancer)		YES
	* Processed under normal Plan benefits, not subject to medical necessity		N/A
	* Other, please specify;		N/A
		100%	Deductible/80%/100%
	Is there coverage of sexual dysfunction/impotence related claims if due to a bodily injury?		
	* No		X
	* Yes, how should sexual dysfunction/impotence related claims due to a bodily injury be processed under the medical plan?		N/A
	* Processed under normal Plan Benefits;		N/A
	* Other, please specify;		N/A
	Is there coverage of sexual dysfunction/impotence related claims if due to a mental disorder?		
	* No		NO
	* Yes, how should sexual dysfunction/impotence related claims due to a bodily injury be processed under the medical plan?		N/A
	* Processed under normal Plan Benefits;		N/A
	* Other, please specify;		N/A

MENTAL DISORDERS, ALCOHOLISM AND CHEMICAL DEPENCENCE

Employee Assistance Program

1 Does the company have an Employee Assistance Program?

_____ Yes
__X__ No

2 Information about the Employee Assistance Program: N/A

Company Name: _____
Contact Name: _____
Address: _____
_____
Telephone Number: _____
Fax Number: _____

3 What service is the Employee Assistance program responsible for? N/A

4 What service is Humana, Inc. responsible for? N/A

5 Is there a penalty that applies when the EAP is not used? N/A

_____ No
_____ Yes, specify; _____

General Services

1 Is marriage counseling covered?

__X__ No
_____ Yes, specify; _____

2 Are prescription drug expenses for mental disorders, alcoholism and chemical dependence subject to the outpatient mental disorders, chemical dependence and alcoholism benefit?

__X__ No
_____ Yes

3 Are x-ray and laboratory expenses for mental disorders, alcoholism and chemical dependence subject to the outpatient mental disorders, chemical dependence and alcoholism benefit?

__X__ No
_____ Yes

4 Does the Plan have a separate transitional care benefit?

_____ No, which benefit applies to the following services?
Partial Hospitalization Programs:
_____ Inpatient _____ Outpatient

__X__ Yes, please refer to that section for further information

5 Are Residential Treatment Centers covered? If so, how are they covered?

__X__ Inpatient _____ Outpatient

MENTAL HEALTH / ALCOHOLISM / CHEMICAL DEPENDENCE -OUTPATIENT SERVICES

1	Out patient services combine with:		
	* Inpatient	NO	
	* Transitional	NO	
	* None	YES	
2	Benefit includes:		
	* Qualified Treatment Facility	YES	
	* General Hospital	YES	
	* Qualified Practitioner (Clinic/Office)	YES	
		Par	**Non-Par**
1	Mental Health/Alcoholism/Chemical Dep	**100%**	**90%**
	* Paid/covered per day	**N/A**	**N/A**
	* Paid/covered per calendar year	**N/A**	**N/A**
	* Paid Plan Year	**$1,800**	**$1,800**
2	Do coinsurance amounts reduce the individual and family out-of-pocket maximums?		
	* Mental Health		**NO**
	* Alcoholism		**NO**
	* Chemical Dependence		**NO**
	* Transitional Care		**N/A**
3	Do the benefits listed above reduce the lifetime maximum of the Plan?		
	* Mental Health		**NO**
	* Alcoholism		**NO**
	* Chemical Dependence		**NO**
	* Transitional Care		**N/A**
4	Is there an Excess benefit:		
	* Mental Health		**NO**
	* Alcoholism		**NO**
	* Chemical Dependence		**NO**
4A	Do the Coinsurance amounts reduce the individual and family out-of-pocket maximums?		
	* Mental Health		**N/A**
	* Alcoholism		**N/A**
	* Chemical Dependence		**N/A**
4B	Do the benefits listed above reduce the lifetime maximum of the Plan ?		
	* Mental Health		**N/A**
	* Alcoholism		**N/A**
	* Chemical Dependence		**N/A**
5	Lifetime Maximum		**NO**
	Limitations - Pd/Cvd / Days		
	* Mental Health		**N/A**
	* Alcoholism		**N/A**
	* Chemical Dependence		**N/A**
6	Does the Lifetime Maximum include:		
	* Mental Health		
	Inpatient	**N/A**	**N/A**
	Outpatient	**N/A**	**N/A**
	Transitional	**N/A**	**N/A**
	* Alcoholism		
	Inpatient	**N/A**	**N/A**

	Outpatient	N/A	N/A
	Transitional	N/A	N/A
	* Chemical Dependence		
	Inpatient	N/A	N/A
	Outpatient	N/A	N/A
	Transitional	N/A	N/A
	* Transitional Care		
	Inpatient	N/A	N/A
	Outpatient	N/A	N/A
7	Does the Lifetime maximum reduce the Lifetime Maximum of the Plan?		
	* Mental Health		N/A
	* Alcoholism		N/A
	* Chemical Dependence		N/A

MENTAL HEALTH / ALCOHOLISM / CHEMICAL DEPENDENCE - INPATIENT SERVICES

1	In patient services combine with:		
	* Outpatient	NO	
	* Transitional	NO	
	* None	N/A	
2	Benefit includes:		
	* Qualified Treatment Facility	YES	
	* General Hospital	YES	
		Par	**Non-Par**
1	Mental Health/Alcoholism/Chemical	**100%**	**80%**
	* Pd/Cov per confinement / cal yr/ pln yr	**N/A**	**N/A**
	* Days per confinement / per plan year	**30 Days Per confinement; 60 days per plan year**	
2	Do coinsurance amounts reduce the individual and family out-of-pocket maximums?		
	* Mental Health		**NO**
	* Alcoholism		**NO**
	* Chemical Dependence		**NO**
3	Do the benefits listed above reduce the lifetime maximum of the Plan?		
	* Mental Health		**NO**
	* Alcoholism		**NO**
	* Chemical Dependence		**NO**
4	Is there an Excess benefit:		
	* Mental Health		**NO**
	* Alcoholism		**NO**
	* Chemical Dependence		**NO**
	Do the Coinsurance amounts reduce the individual and family out-of-pocket maximums?		
	* Mental Health		**N/A**
	* Alcoholism		**N/A**
	* Chemical Dependence		**N/A**
	Do the benefits listed above reduce the lifetime maximum of the Plan ?		
	* Mental Health		**N/A**
	* Alcoholism		**N/A**
	* Chemical Dependence		**N/A**
5	Lifetime Maximum		
	Limitations - Pd/Cvd / Days	**N/A**	**N/A**
	* Mental Health	**N/A**	**N/A**
	* Alcoholism	**N/A**	**N/A**
	* Chemical Dependence	**N/A**	**N/A**
6	Does the Lifetime Maximum include:		
	* Mental Health		
	Inpatient	**N/A**	**N/A**
	Outpatient	**N/A**	**N/A**
	* Alcoholism		
	Inpatient	**N/A**	**N/A**
	Outpatient	**N/A**	**N/A**
	* Chemical Dependence		
	Inpatient	**N/A**	**N/A**
	Outpatient	**N/A**	**N/A**

7	Does the Lifetime maximum reduce the Lifetime Maximum of the Plan?		
	* Mental Health	N/A	N/A
	* Alcoholism	N/A	N/A
	* Chemical Dependence	N/A	N/A

MENTAL HEALTH / ALCOHOLISM / CHEMICAL DEPENDENCE -TRANSITIONAL CARE

1	Transitional services combine with:		
	* Outpatient	NO	
	* Inpatient	NO	
	* None	YES	
2	Benefit includes:		
	* Qualified Treatment Facility	YES	
	* General Hospital	YES	
	* Qualified Practitioner (Clinic/Office)	YES	
		Par	Non-Par
1	Mental Health/Alcoholism/Chemical	100%	90%
	* Paid/covered per day	N/A	N/A
	* Paid/covered per calendar year	N/A	N/A
	* Paid Plan Year	$2,700	$2,700
2	Do coinsurance amounts reduce the individual and family out-of-pocket maximums?		
	* Mental Health		NO
	* Alcoholism		NO
	* Chemical Dependence		NO
3	Do the benefits listed above reduce the lifetime maximum of the Plan?		
	* Mental Health		NO
	* Alcoholism		NO
	* Chemical Dependence		NO
4	Is there an Excess benefit:		
	* Mental Health		NO
	* Alcoholism		NO
	* Chemical Dependence		NO
4.a	Do the Coinsurance amounts reduce the individual and family out-of-pocket maximums?		N/A
4B	Do the benefits listed above reduce the lifetime maximum of the Plan ?		NO
5	Lifetime Maximum	NO	NO
6	Does the Lifetime maximum reduce the Lifetime Maximum of the Plan?		N/A

This document has been completed by: _____

Humana Implementation Team

This document has been reviewed with: _____

Name of the Company: _____

Date Received: _____

It has been agreed that this document will be used to build the Plan(s) for administration, including benefits, assembly of the summary plan description(s) and future reference. Completion of the Claims Payment Agreement - Plan Change Document authorizes Humana, Inc. the right to process and make payment on claims submitted by Participants in the Plan, on their behalf and on behalf of their covered dependents, for benefits under the Plan during the period prior to the printing and delivery to the Client and Humana, Inc. of a final summary plan description.