Church Pension Group Services Corporation

2009 HMO Renewals

Plan Design: Ochsner- LA

Carrier	Humana Health Plans, Inc.
Plan Name	Humana (Ochsner)- LA
Plan Location	Louisiana
Plan Year	2009
Member Services Telephone	866-427-74-78
Member Services Hours Weekdays	8:00-6:00 EST
Member Services Hours Weekends	Automated Line
Self-referral to OB-GYN	Yes
Self-referral to Specialist	Yes
Default PCP assigned if none chosen?	Yes
Calendar year deductible	N/A
Annual out-of-pocket maximum	$2,000 Individual/$6,000 Family
Lifetime maximum coverage per person	Unlimite
Out of area dependent coverage	Emergency coverage only
Conversion privilege/policy at the end of The Medical Trust Extension Period	
Web Site Address	www.humana.com
Are participants required to file claims?	No
Routine Office Visit	$15 Copay
Physician Home Visit	Not covered
Specialty Care	$30 Copay
Annual physical exam	100% covered after $15 copay for primary physician or $30 copay for specialist
Pediatric Exams	100% covered after $15 copay for primary physician or $30 copay for specialist
Cancer Screenings	100% covered after $15 copay for primary physician or $30 copay for specialist
Cardiovascular Screenings	$15 Copay or $30 copay for specialist may be included as part of the annual physical exam
Pap Smears (annually)	100% covered after $15 copay for primary physician or $30 copay for specialist
Mammography	100% covered after $15 copay for primary physician or $30 copay for specialist
Immunizations: Adult	100% Covered to age 18 (not covered for school, work, travel)
Immunizations: Child	100% covered (not covered for school, work, travel)
Allergy tests and treatments	100% covered after $15 copay for primary physician or $30 copay for specialist. See comments for additional information.
Additional Comments	Allergy injections : 100% ater $5 copayment
Second surgical opinion	100% covered after $15 copay for primary physician or $30 copay for specialist
Lab	100% covered after $15 copay for primary physician or $30 copay for specialist
X-Ray	100% covered after $15 copay for primary physician or $30 copay for specialist
Outpatient surgery	$100 covered aftr $50 copayment per visit
Physical Therapy	100% covered after $30 copay per visit (maximum of 60 days per calendar year) Combined with Speech Therapy
Occupational Therapy	100% covered after $30 copay per visit
Speech Therapy	100% covered after $30 copay per visit (maximum of 60 days per calendar year) Combined with Physical therapy
Chiropractic Services	100% covered after $30 copay for specialist
Audiometric exam	Routine hearing screening : 100% after $15 copay or $30 copay for specialist
Hearing evaluation test	100% covered after $15 copay for primary physician or $30 copay for specialist
Hearing hardware (Hearing aid)	See comments
Additional Comments	Hearing Aids (to age 18, coverage for non disposable aids, up to $1400 per hearing aid, every 36th months for each hearing impaired ear)
Eye care referral required	No
Routine Eye Exams (includes refraction)	100% covered after $15 copay
Exam for the treatment of disease or injury to the eye	100% covered after $15 copay for primary physician or $30 copay for specialist
Regular lenses and frames	Discount Only applies: 45% off retail up to $130 through EyeMed Providers Only
Contact lenses	Discount Onply Applies through EyeMed providers: 15% off retail price
Cataract surgery	100% covered after $100 copayment per day for first five days per admission- Inpat services or $50 copay per visit for Outpatient surgery

Annual Rx deductible	N/A
Annual Rx maximum	2,500 per calendar yr, per member for level 4 drugs. Level 4 drugs include high-technology drugs, certain brand-name drgs, biotechnology drugs, and self- administered injectable medication.
Retail: Generic	Level 1: $10
Retail: Formulary Brand	Level 2: $25
Retail: Non-formulary Brand	Level 3: $45
Mail Order: Generic	Level 1: $25
Mail Order: Formulary Brand	Level 2: $62.50
Mail Order: Non-formulary Brand	Level 3: $112.50
Mandatory formulary list	Yes
Number of drugs on formulary	See attached list
Generic Requirement	Yes
Oral Contraceptives	See attached list
Diaphragms	
Fertility drugs	Not Covered
Viagra	Not covered
Additional Comments	Level 4 drugs: 25%
Physician's office: Pre/Post-natal	Office Visit Copayment for pre-natal care required for 1st visit only
In hospital: Physician's services	100% after Hospital copayment
Newborn nursery services	Same as Inpatient or Outpatient Hospital
Infertility services	Not cevered
In vitro fertilization	Not cevered
Artificial insemination	Not cevered
Female tubal	Same as Inpatient or Outpatient Hospital
Male vasectomy	Same as Inpatient or Outpatient Hospital
Elective abortion	Not Covered
Birthing centers, licensed and certified	Yes, while dependent is covered on the plan.
Maternity coverage for unmarried female dependents	Yes, Offie viit copay for pre-natal care required for 1st visit only. Same as Inpatient Hosptal for delivery.
Automatic coverage from birth for baby if parent is enrolled at baby's birth	Baby must be added to the plan within 31 days of DOB for automatic coverage. Nursey services/delivery covered if mom is enrolled on plan.
Midwives, licensed and certified	Certified Nurse Midwife only
Hospital copay	100% covered after $100 copayment per day for first five days per admission
Semi-private care	Included in Hospital copay
Private care	100% covered after Hospital copay/deductible; when medically necessary.
Intensive care	100% covered after Hospital copay/deductible; when medically necessary.
Additional Comments	
Lab and X-Ray	100% covered after $15 copay for primary physician or $30 copay for specialist
Surgery	100% covered after $100 copayment per day for first five days per admission. Inpat surgery
Affiliated Hospitals	100% covered after $100 copayment per day for first five days per admission
Non-participating Hospitals	100% covered; for emergency only. Subject to applicable copays and limitations.
Physician/Surgeon services	Included in Hospital copay
Surgical assistance	Included in Hospital copay
Ancillary services	Included in Hospital copay
Consultations	Included in Hospital copay
Special duty nursing	Not covered
Physical therapy	Included in Hospital copay
Renal Dialysis	100% covered after $100 copayment per day for first five days per admission
Anesthesia	Included in Hospital copay
Blood transfusion (if not replaced)	100% covered when medically necessary, blood not covered.
Pulmonary Tuberculosis	100% covered after Hospital copay/deductible; when medically necessary.
Heart	Same as any other illness subject to any applicable copayment limitation
Kidney	Same as any other illness subject to any applicable copayment limitation
Liver	Same as any other illness subject to any applicable copayment limitation
Lung	Same as any other illness subject to any applicable copayment limitation
Cornea	Same as any other illness subject to any applicable copayment limitation
Bone marrow	Same as any other illness subject to any applicable copayment limitation
In-Area (when followed by admission)	100% covered after $100 copayment per day for first five days per admission
In-Area (when not followed by admission)	100% covered after $75 copay per visit (waived if admitted)
Out-of-Area (when followed by admission)	Life or Limb threatning only. 100% coverage after $100 copayment per day for first five days per admission
Out-of-Area (when not followed by admission)	Life or Limb threatning only. 100% covered after $75 copayment
Urgent care Clinic visit	100% covered $30 copay for specialist
Ambulance	100% covered; when medically necessary - participating providers; subject to usual, customary, and reasonable charges - non participating providers
Additional Comments	This is a summary only and is not intended to be a complete description of covered services. More complete information is contained in the Group Contract/Certificate. If a discrepancy arises between this benefit summary and the actual Group Contract/Certi

Combined with substance abuse	Yes
Outpatient- Coverage level/Visits	100% covered after $100 copay per deay for first five days per admission (maximum of 20 dyas per calendar year)
Inpatient- Coverage level/Visits	100% covered after $100 copay per deay for first five days per admission (maximum of 30 dyas per calendar year)
Additional Comments	Severe Mental Illness: Inpatient - maximum of 45 dyas per calendar year; Outpatient - maximum of 52 visits per calendar year)
Detox Outpatient- Coverage level/Visits	Detoxification Services (inpatient or outpatient as medically necessary) - Facility - covered at 80%
Detox Inpatient- Coverage level/Visits	Detoxification Services (inpatient or outpatient as medically necessary) - Facility - covered at 80%
Rehab Outpatient- Coverage level/Visits	combined with mental heatlh
Rehab Inpatient- Coverage level/Visits	combined with mental heatlh
Surgery	Not covered
Appliances	Not covered
Therapy	Not covered
Implants	Not covered
Accidental Injury to Teeth	Covered for an injury to sound natural teeth; an office visit, ER, or outpatient surgery copay may apply.
Surgical Removal of Tumors, Cysts, & Impacted Teeth	Not covered
Additional Comments	Professional services for the diagnosis and treatment of disease or defects, or accidental injury to the teeth, gums, jaws and associated structures, and the alveolar processes. Dental Services include dental examinations and consultations, and oral surgery and hospitalization for dental related care
Noncustodial home health care	100% covered
Hospice care	100% covered
Prescribed care in a Noncustodial skilled nursing facility	100% covered
Acupuncture	Not covered
Durable Medical Equipment	100% covered
Additional Comments	