

HumanaHMO Summary of Benefits

TEXAS HMO 1

Plan pays for services provided or arranged by your **PARTICIPATING** primary care physician

Preventive Care	<ul style="list-style-type: none"> • Routine immunizations for children birth through age six • Routine immunizations (<i>except for work or foreign travel</i>) • Routine physical exams • Routine lab and X-ray • Routine mammogram • Well-child care • Well-woman exam (<i>may self-refer to OB/GYN</i>) • Annual prostate cancer detection exam • Speech, hearing and eye screening exams 	<p>100%</p> <p>100% after \$15 copayment per visit to primary care physician or \$30 copayment per visit to specialist</p>
Physician Services <i>(most visits to specialists must be authorized by a primary care physician)</i>	<ul style="list-style-type: none"> • Primary care physician office visits (<i>office visits in conjunction with an illness or injury</i>) • Specialty physician office visits • Prenatal care (<i>office visit copayment applies to first visit only</i>) • Diagnostic tests, procedures or X-ray exams, including interpretation • Allergy tests • Allergy injections • Emergency room visits • Allergy serum • Inpatient visits 	<p>100% after \$15 copayment per visit</p> <p>100% after \$30 copayment per visit</p> <p>100% after \$15 copayment per visit to primary care physician or \$30 copayment per visit to specialist</p> <p>100% after \$5 copayment per visit</p> <p>100%</p>
Hospital Services	<ul style="list-style-type: none"> • Inpatient care (<i>semiprivate room, ancillary services, physician visits; includes maternity services</i>) (1) • Preadmission testing • Outpatient surgical care (<i>includes ambulatory surgical center</i>) (1) • Outpatient nonsurgical care (<i>including diagnostic lab and X-ray</i>) • Emergency care (<i>emergency room, emergency services</i>) 	<p>100% after \$100 copayment per day for first five days per admission</p> <p>100%</p> <p>100% after \$50 copayment per visit</p> <p>100%</p> <p>100% after \$75 copayment per visit (<i>copayment is waived if admitted</i>)</p>
Prescription Drugs	Please see attached pharmacy benefit information, if applicable.	
Other Medical Services	<ul style="list-style-type: none"> • Skilled nursing facility (<i>up to 100 days per calendar year</i>) • Home health care (1) • Ambulance 	100%

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.

HMO 1

Plan pays for services provided or arranged by your *PARTICIPATING* primary care physician

Other Medical Services <i>(cont.)</i>	<ul style="list-style-type: none"> • Durable medical equipment (1) • Hospice services (1) 	100%
	<ul style="list-style-type: none"> • Physical, occupational, hearing and speech therapy (1) 	100% after \$30 copayment per visit
	<ul style="list-style-type: none"> • Diabetes services <ul style="list-style-type: none"> – Diabetes self-management training 	100% after \$15 copayment per visit to primary care physician or \$30 copayment per visit to specialist
	<ul style="list-style-type: none"> – Diabetes equipment – Diabetes supplies <i>(30-day supply per copayment)</i> 	100% Subject to the applicable prescription drug copayment. If drug coverage is not available, then a \$5 generic (on the Drug List)/\$15 brand (on the Drug List)/\$30 (not on the Drug List) copayment applies
	<ul style="list-style-type: none"> • Transplant services (1) 	Same as any other illness subject to any applicable copayment limitation.
Mental Health Services	<ul style="list-style-type: none"> • Inpatient <i>(maximum of 10 days per calendar year)</i> (1) 	100% after \$100 copayment per day for first five days per admission
	<ul style="list-style-type: none"> • Outpatient <i>(maximum of 20 one-hour visits per calendar year)</i> 	100% after \$30 copayment per visit
	<ul style="list-style-type: none"> • Psychiatric day treatment <i>(two days equal to one inpatient day)</i> 	100%
Serious Mental Illness	<ul style="list-style-type: none"> • Inpatient <i>(maximum of 45 days per calendar year)</i> • Outpatient <i>(maximum of 60 visits per calendar year)</i> 	Same as any other illness subject to any applicable copayment limitation.
	<ul style="list-style-type: none"> • Inpatient • Outpatient 	Same as any other illness subject to any applicable copayment limitation.
Chemical Dependency Services <i>(lifetime maximum of three separate series of treatment per member)</i>	<ul style="list-style-type: none"> • Inpatient • Outpatient 	Same as any other illness subject to any applicable copayment limitation.
Copayment Limits	<ul style="list-style-type: none"> • Individual 	\$2,000
	<ul style="list-style-type: none"> • Family 	\$6,000

Most medical services must be provided or arranged by your participating primary care physician. 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 Certificate for more information on medical necessity and other specific plan benefits.

(1) Prior authorization required in order to receive these benefits.

The amount of benefits 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

This is a partial and summarized list of limitations and exclusions. Your group may have specific limitations and exclusions not included on this list. Please check your Certificate of Coverage for this complete listing. The Certificate of Coverage is the document upon which benefit payment will be determined.

Pre-existing condition limitation

Health insurance benefits are excluded for a pre-existing condition for 12 consecutive months following your enrollment date, 18 months for late applicants. The exclusion does not apply to:

- Pregnancy;
- Genetic information in the absence of a diagnosis of the condition related to the information; or
- Newborn children or children adopted before the age of 18 if they are covered under the master group contract within 31 days of the date of birth or date of placement for adoption.

The pre-existing condition limitation shall not be applied to you if you were continuously covered for an aggregate period of 12 months under creditable coverage.

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 preventive services as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of this 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 that 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. Services provided to you, if you do not comply with the master group contract's requirements. These include services:
 - a. Not provided by a network provider, unless required for emergency care; (Unless specifically stated on this benefit summary.)
 - b. Received in an emergency room, unless required because of emergency care;
 - c. Which require preauthorization if preauthorization was not obtained.

- d. Which require a primary care physician referral if a referral was not obtained. (Unless specifically stated on this benefit summary.)
5. Any drug, biological product, device, medical treatment, or procedure which is experimental, or investigational or for research purposes.
6. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.
7. Prescription drugs, including vitamins and self-administered injectable drugs unless administered to you:
 - a. While an inpatient in a hospital, skilled nursing facility, health care treatment facility, residential treatment facility, psychiatric day treatment facility, crisis stabilization unit, residential treatment center for children or adolescents, or chemical dependency treatment center;
 - b. By a health care practitioner during an office visit; or
 - c. By a home health care agency as part of a covered home health care plan when approved by us.
8. Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.
9. In-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; infertility services; sex change services; or reversal of elective sterilization.
10. Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
 - a. Resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or
 - b. Resulting from congenital disease or anomaly of a covered dependent child which resulted in a functional impairment; or
 - c. Resulting from craniofacial abnormalities of a covered dependent child to improve the function of or attempt to create a normal appearance.

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.
11. 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 this certificate.
12. Custodial care and maintenance care.
13. Any treatment, including but not limited to surgical procedures:
 - a. For obesity, which includes morbid obesity; or
 - b. 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.
14. Alternative medicine.
15. Chiropractic services or spinal manipulations.
16. 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 this certificate).
17. Expenses for treatment of complications of non-covered procedures or services.
18. Any care, treatment, services, equipment or supplies received outside of the service area:
 - a. If you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
 - b. Which are not authorized by us or to the extent they exceed the maximum allowable fee.
 - c. Unless received by an employee's dependent child who resides outside the service area and who is covered under the master group contract as a result of a valid child medical support order.

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.

HUMANA
Guidance when you need it most

Offered by Humana Health Plan of Texas, Inc. –
a Health Maintenance Organization