

TEXAS PPO 300 90/60 PRV		PARTICIPATING providers	NONPARTICIPATING providers
Preventive Care	<ul style="list-style-type: none"> Routine immunizations (<i>birth to age seven</i>) 	100%	100%
	<ul style="list-style-type: none"> Routine immunizations (<i>age seven to age 18</i>) Annual routine mammogram Annual routine Pap smear Routine adult lab and X-ray 	100%	Deductible then 70%
	<ul style="list-style-type: none"> Annual routine adult physical examinations (<i>18 years and above</i>) Routine child physical examinations (<i>up to age 18</i>) 	100% after \$20 copayment per visit to a Level One participating physician or \$35 copayment per visit to a Level Two participating physician*	Deductible then 70%
Physician Services	<ul style="list-style-type: none"> Office visits (<i>includes diagnostic lab/X-ray, allergy testing</i>) (<i>excludes outpatient surgery</i>) Prenatal care (<i>office visit copayment applies to first visit only</i>) 	100% after \$20 copayment per visit to a Level One participating physician or \$35 copayment per visit to a Level Two participating physician*	Deductible then 70%
	<ul style="list-style-type: none"> Allergy serum Inpatient services Outpatient services (<i>includes surgery</i>) 	Deductible then 90%	Deductible then 60%
	<ul style="list-style-type: none"> Physician visits to emergency room (1) 	Deductible then 90%	Participating deductible then 90%
	<ul style="list-style-type: none"> Allergy injections 	100% after \$5 copayment per visit	Deductible then 70%
Hospital Services	<ul style="list-style-type: none"> Inpatient care (<i>semiprivate room and board, nursing care, ICU</i>) 	100% after \$150 copayment per day for first five days per admission, and after deductible	Deductible then 70%
	<ul style="list-style-type: none"> Outpatient surgery - facility 	100% after \$50 copayment per procedure after deductible	Deductible then 70%
	<ul style="list-style-type: none"> Outpatient nonsurgical (<i>including diagnostic lab and X-ray</i>) 	Deductible then 90%	Deductible then 60%
	<ul style="list-style-type: none"> Emergency room (1) 	100% after \$100 copayment per visit after deductible (<i>copayment waived if admitted</i>)	100% after \$100 copayment per visit after participating deductible (<i>copayment waived if admitted</i>)
Prescription Drugs	<ul style="list-style-type: none"> Please see attached pharmacy benefit information, if applicable. 		
Other Medical Services	<ul style="list-style-type: none"> Skilled nursing facility (<i>up to 60 days per calendar year</i>) Home health care (<i>up to 100 visits per calendar year</i>) Durable medical equipment Physical, speech and hearing therapy (4) Private duty nursing (<i>inpatient hospital only</i>) Hospice 	Deductible then 90%	Deductible then 60%

PPO 300 90/60 PRV		PARTICIPATING providers	NONPARTICIPATING providers
Other Medical Services (cont.)	• Ambulance (1)	Deductible then 90%	Participating deductible then 90%
	• Transplant services (2)	Deductible then 100%	Deductible then 70%
Mental Health Services (3)	• Inpatient (up to 30 days per calendar year)	100% after \$150 copayment per day for first five days per admission	Deductible then 70%
	• Inpatient professional services	90%	60%
	• Outpatient (up to 30 visits per calendar year) – Individual sessions	100% after a \$35 copayment per visit	70%
	– Group sessions	100% after a \$20 copayment per visit	70%
Serious Mental Illness	• Inpatient (up to 45 days per calendar year)	Covered the same as any other illness	Covered the same as any other illness
	• Outpatient (up to 60 visits per calendar year)		
Chemical Dependency Services (lifetime maximum of three separate series of treatments for each insured person)	• Inpatient	Covered the same as any other illness	Covered the same as any other illness
	• Outpatient		
Annual Deductible (per calendar year) (copayments do not apply)	• Individual	\$300	\$600
	• Family (5)	\$900	\$1,800
Maximum Out-Of-Pocket Expense Limit (per calendar year) (excludes deductibles and copayments)	• Individual	\$2,500	\$5,000
	• Family	\$7,500	\$15,000
Lifetime Maximum Benefit		\$5,000,000	

* Level One participating physicians include family practitioner, general practitioner, pediatrician or internist and Level Two contains any other participating physician. Please contact Customer Service for details.

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.

Payments - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Certificate.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or

copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

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.

Emergency services received while out of the service area are covered at participating provider level.

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) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.
- (2) Transplant services do not apply toward the maximum out-of-pocket expense limit.

- (3) Any out-of-pocket expense for the treatment of mental health services does not apply towards any out-of-pocket expense limits except for serious mental illness.
- (4) Subject to certain limitations and exclusions. Refer to the Certificate for additional information.
- (5) You are not required to meet individual deductibles once the family deductible has been met.

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. Limitations and exclusions to coverage 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 any procedure, treatment or supply. This guide is available at Humana.com/members/enrollment-center/pre-enrollment-disclosures or through your sales representative.

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.

PRE-EXISTING CONDITION EXCLUSION

If the plan imposes a pre-existing condition exclusion, and 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; genetic information in the absence of a diagnosis of the condition related to the information; 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.

HUMANA
Guidance when you need it most