HUMANA INSURANCE COMPANY: TX SG HUMANA PPO 11 SEP ACC&CPY OV&DED/COINS IP/OP

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 08/01/2015

Coverage For: Individual + Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.humana.com** or by calling **1-800-833-6917**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: $3,000 Individual / $6,000 Family Non-Network: $9,000 Individual / $18,000 Family Doesn't apply to prescription drugs and preventive services. Co-insurance and co-payments don't count toward the deductible	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses	Yes. For Network providers For Non-Network providers $9,000 Individual / $18,000 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance-billed charges, Health care this plan doesn't cover, Penalties, Non-network transplant, Co-Payments, Deductibles, Out-of-network Co-Insurance, prescription drugs, specialty drugs	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.humana.com or call 1-800-833-6917** for a list of Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	30% coinsurance	n o n e
	Specialist visit	$55 copay/visit	30% coinsurance	n o n e
	Other practitioner office visit	Chiropractor Exam: $55 copay/visit	Chiropractor Exam: 30% coinsurance	n o n e
	Preventive care / screening / immunization	No charge	30% coinsurance	limited coverage for preventive care
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	30% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% coinsurance	Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.humana.com.**	Level 1 - Lowest cost generic and brand-name drugs	$10 copay (Retail) $25 copay (Mail Order)	30% coinsurance, after Network copay (Retail) Not Covered (Mail Order)	30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order)
	Level 2 - Higher cost generic and brand-name drugs	$40 copay (Retail) $100 copay (Mail Order)	30% coinsurance, after Network copay (Retail) Not Covered (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	$70 copay (Retail) $175 copay (Mail Order)	30% coinsurance, after Network copay (Retail) Not Covered (Mail Order)	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	30% coinsurance, after Network copay (Retail) Not Covered (Mail Order)	
	Specialty drugs	35% coinsurance	50% coinsurance	25% coinsurance when filled via a preferred network specialty pharmacy Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	No charge after deductible	30% coinsurance	none
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Copayment waived if admitted
	Emergency medical transportation	No charge after deductible	No charge after deductible	none
	Urgent care	$55 copay/visit	30% coinsurance	none

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% coinsurance	preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fee	No charge after deductible	30% coinsurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$55 copay/visit	30% coinsurance	15 visits per calendar year
	Mental/Behavioral health inpatient services	No charge after deductible	30% coinsurance	10 days per calendar year 3 separate series of treatment for each covered member preauthorization may be required - if not obtained, penalty will be 50%
	Substance use disorder outpatient services	$55 copay/visit	30% coinsurance	15 visits per calendar year
	Substance use disorder inpatient services	No charge after deductible	30% coinsurance	10 days per calendar year 3 separate series of treatment for each covered member preauthorization may be required - if not obtained, penalty will be 50%
If you are pregnant	Prenatal and postnatal care			none
	Delivery and all inpatient services	No charge after deductible	30% coinsurance	preauthorization may be required - if not obtained, penalty will be 50%
If you need help recovering or have other special health needs	Home health care	No charge after deductible	30% coinsurance	100 visits per calendar year Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	Rehabilitation, Physical, Occupational, Speech, and Audiology Therapy: $55 copay/visit	Rehabilitation, Physical, Occupational, Speech, and Audiology Therapy: 30% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50% Manipulations, Physical, and Occupational Therapy: 30 visits per calendar year, includes PT/OT, manips, adjustments For non-network, 10 visits per calendar year, includes PT/OT, manips, adjustments

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Habilitation services	Habilitation, Physical, Occupational, Speech, and Audiology Therapy: $55 copay/visit	Habilitation, Physical, Occupational, Speech, and Audiology Therapy: 30% coinsurance	
	Skilled nursing care	No charge after deductible	30% coinsurance	60 days per calendar year Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50% for durable medical equipment $750 and over
	Hospice service	No charge after deductible	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Long-term care
- Non Emergent Care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care - spinal manipulations are covered
- Hearing Aids

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-833-6917. You may also contact your state insurance department at Texas Department of Insurance, PO Box 149104, Austin, TX 78714-9104, Phone: 512-463-6169 or 800-252-3439, Website: http://www.tdi.texas.gov/index.html.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Texas Department of Insurance, PO Box 149104, Austin, TX 78714-9104, Phone: 512-463-6169 or 800-252-3439, Website: http://www.tdi.texas.gov/index.html

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does provide minimum essential coverage for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-833-6917

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $4,540
- Patient pays $3,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$3,000**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $4,980
- Patient pays $420

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$400
Coinsurance	$0
Limits or exclusions	$20
Total	**$420**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from network **providers**. If the patient had received care from non-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

û **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

û **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

ü **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

ü **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.