



life care

HIGH DEDUCTIBLE HEALTH PLAN 100/70

PREFERRED PROVIDER BENEFIT PLAN

TEXAS Plan 38, Option 200

Plan pays for services from
PARTICIPATING providers

Plan pays for services from
NONPARTICIPATING providers

		Single Deductible	Family Deductible (2)	Single Deductible	Family Deductible (2)
Annual Deductible (1)	<ul style="list-style-type: none"> Annual amount 	\$3,000 \$5,000	\$6,000 \$10,000	\$6,000 \$10,000	\$12,000 \$20,000
Maximum Out-of-Pocket Expense Limit (1), (2)	<ul style="list-style-type: none"> Individual Family 	\$0		\$6,000 \$12,000	
Lifetime Maximum Benefit		\$5,000,000 per covered person			
Preventive Care	<ul style="list-style-type: none"> Annual routine physical exam (3), (4) Routine immunizations (birth to age 6) Routine immunizations (age 6 to age 18) (3), (4) Routine mammogram (5) Routine Pap smear (3), (4), (5) Colorectal detection screening PSA (5) Routine lab, pathology and X-ray (3), (4) 	100% 100% after deductible		70% after deductible 70% after deductible	
Physician Services	<ul style="list-style-type: none"> Office visits (includes diagnostic lab and X-ray) Allergy testing, injections and serum Inpatient services Outpatient services (includes surgery) (6) 	100% after deductible		70% after deductible	
Hospital Services	<ul style="list-style-type: none"> Inpatient care Outpatient surgery – facility (6) Outpatient nonsurgical Emergency room (including physician visits) 	100% after deductible		70% after deductible	
Prescription Drugs (7)	<ul style="list-style-type: none"> Benefit for each prescription or refill (up to 30-day supply) Mail order (90-day supply) 	100% after deductible		70% after deductible	
Other Medical Services	<ul style="list-style-type: none"> Skilled nursing facility (up to 30 days per calendar year) (8) Home health care (up to 60 visits per calendar year) (8) Durable medical equipment (up to \$2,500 per calendar year) (8) Hospice (8), (9) Complications of pregnancy and sick baby services Transplant services (organ) (8) 	100% after deductible 100% after deductible (when services are performed at a National Transplant Network provider)		70% after deductible 70% after deductible (subject to separate out-of-pocket maximum of \$35,000 per calendar year)	
Mental Health (includes mental disorders, alcohol and chemical dependence, waiting period applies) (3)	<ul style="list-style-type: none"> Inpatient and Outpatient care (Combined \$2,500 per calendar year maximum. Outpatient care not to exceed \$500 of the \$2,500 calendar year maximum.) 	75% after deductible		50% after deductible	



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HIGH DEDUCTIBLE HEALTH PLAN 80/60

PREFERRED PROVIDER BENEFIT PLAN

TEXAS Plan 38, Option 201

Plan pays for services from
PARTICIPATING providers

Plan pays for services from
NONPARTICIPATING providers

		Single Deductible	Family Deductible (2)	Single Deductible	Family Deductible (2)
Annual Deductible (1)	<ul style="list-style-type: none"> Annual amount 	\$2,000 \$3,000	\$4,000 \$6,000	\$4,000 \$6,000	\$8,000 \$12,000
Maximum Out-of-Pocket Expense Limit (1), (2)	<ul style="list-style-type: none"> Individual Family 	\$2,000	\$4,000	\$8,000	\$16,000
Lifetime Maximum Benefit		\$5,000,000 per covered person			
Preventive Care	<ul style="list-style-type: none"> Annual routine physical exam (3), (4) Routine immunizations (birth to age 6) Routine immunizations (age 6 to age 18) (3), (4) Routine mammogram (5) Routine Pap smear (3), (4), (5) Colorectal detection screening PSA (5) Routine lab, pathology and X-ray (3), (4) 	80% 100% 80%		60% after deductible 100% 60% after deductible	
Physician Services	<ul style="list-style-type: none"> Office visits (includes diagnostic lab and X-ray) Allergy testing, injections and serum Inpatient services Outpatient services (includes surgery) (6) 	80% after deductible		60% after deductible	
Hospital Services	<ul style="list-style-type: none"> Inpatient care Outpatient surgery – facility (6) Outpatient nonsurgical Emergency room (including physician visits) 	80% after deductible		60% after deductible	
Prescription Drugs (7)	<ul style="list-style-type: none"> Benefit for each prescription or refill (up to 30-day supply) Mail order (90-day supply) 	80% after deductible		60% after deductible	
Other Medical Services	<ul style="list-style-type: none"> Skilled nursing facility (up to 30 days per calendar year) (8) Home health care (up to 60 visits per calendar year) (8) Durable medical equipment (up to \$2,500 maximum per calendar year) (8) Hospice (8), (9) Complications of pregnancy and sick baby services Transplant services (organ) (8) 	80% after deductible 75% after deductible 80% after deductible 80% after deductible		60% after deductible 50% after deductible 60% after deductible	
Mental Health (includes mental disorders, alcohol and chemical dependence, waiting period applies) (3)	<ul style="list-style-type: none"> Inpatient and Outpatient care (Combined \$2,500 per calendar year maximum. Outpatient care not to exceed \$500 of the \$2,500 calendar year maximum.) 	75% after deductible		50% after deductible	



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To be covered, expenses must be medically necessary and specified as covered. Please see your policy for more information on medical necessity and other specific plan benefits.

- (1) Must meet deductible in addition to the out-of-pocket maximum. The medical out-of-pocket maximum does not apply to transplant services or mental health services from National Transplant Network providers.
- (2) For other than single coverage, the family deductible applies. The single deductible applies to single coverage policies only.

- (3) Benefit payable after 90-day waiting period for preventive care and 30-day waiting period for mental health.
- (4) \$300 of covered expenses per person per calendar year, subject to applicable coinsurance.
- (5) Age and/or frequency limits apply.
- (6) Outpatient benefits payable after 90-day waiting period for nonemergency removal of tonsils and/or adenoids, and 180-day waiting period for nonemergency surgical treatment for bunions, varicose veins, hemorrhoids or hernia (does not include strangulated or

- incarcerated hernia).
- (7) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- (8) Prior authorization required in order to be eligible for these benefits.
- (9) Counseling for hospice patient and immediate family is limited to 15 visits per family per lifetime, Medical Social Services limited to \$100 per family per lifetime.

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 policy.

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 Insurance Company's networks are not the

agents, employees or partners of Humana Insurance Company or any of its affiliates or subsidiaries. They are independent contractors. Humana Insurance Company is not a provider of medical services. Humana Insurance Company does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.

HealthMiles Plus is brought to you by Virgin Life Care and Humana and is insured by Humana Insurance Company.



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MEDICAL LIMITATIONS AND EXCLUSIONS

This is an outline of the limitations and exclusions for the Humana Individual Health Plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

PRE-EXISTING CONDITIONS

A pre-existing condition is a sickness or injury which was diagnosed or treated, or which produced signs or symptoms that would cause an ordinary prudent person to seek treatment, during the five-year period before the covered person's effective date of coverage. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with us. We will waive the pre-existing conditions limitation for those conditions disclosed on the application provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

OTHER EXPENSES NOT COVERED

Unless stated otherwise no benefits are payable for expenses arising from:

1. Services not medically necessary or which are experimental, investigational or for research purposes.
2. Services not authorized or prescribed by a health care practitioner or for which no charge is made.
3. Services while confined in a hospital or other facility owned or operated by the United States government, provided by a person who ordinarily resides in the covered person's home or who is a family member, or that are performed in association with a service that is not covered under the policy.
4. Charges in excess of the maximum allowable fee or which exceed any policy benefit maximum.
5. Expenses incurred before the effective date or after the date coverage terminated.
6. Cosmetic procedures and any related complications except as stated in the policy.
7. Custodial or maintenance care.
8. Any drug, medicine or device which is not FDA approved.
9. Medications, drugs or hormones to stimulate growth.
10. Legend drugs not recommended or deemed necessary by a health care practitioner or drugs prescribed for a noncovered injury or sickness.
11. Drugs prescribed for intended use other than for indications approved by the FDA or recognized off-label indications through peer-reviewed medical literature, experimental or investigational use drugs.
12. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
13. Drugs used in treatment of nail fungus.
14. Prescription refills exceeding the number specified by the health care practitioner or dispensed more than one year from the date of the original order.
15. Vitamins, dietary products and any other nonprescription supplements.
16. Infertility services.
17. Pregnancy and well-baby expenses.
18. Elective medical or surgical procedures; abortion; gender change or sexual dysfunction.
19. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses; hearing aids; dental exams.
20. Hearing exams (except for children from birth through 24 months of age); eye exams; routine physical exams for occupation, employment, school, travel, purchase of insurance or premarital tests.
21. Dental services (except for dental injury), appliances or supplies.
22. War or any act of war, whether declared or not; commission or attempt to commit a civil or criminal battery or felony.
23. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the policy.
24. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat sickness or bodily injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures.
25. Nicotine habit or addiction; educational or vocation therapy, services and schools; light treatment for Seasonal Affective Disorder (S.A.D.); alternative medicine; marital counseling; genetic testing, counseling or services; sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
26. Foot care services except as stated in the policy.
27. Charges for nonmedical purposes or used for environmental control or enhancement (whether or not prescribed by a health care practitioner).
28. Health clubs or health spas, aerobic and strength conditioning, work hardening programs and related material and products for these programs; personal computers and related or similar equipment; communication devices other than due to surgical removal of the larynx or permanent lack of function of the larynx.
29. Hair prosthesis, hair transplants or implants and wigs.
30. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders, and any treatment for jaw, joint or head and neck neuromuscular disorder.
31. Injury or sickness arising out of or in the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to a covered person qualifying as a sole proprietor, officer or partner under state law, and such benefits are not covered under any Workers' Compensation plan, provided the covered person is not covered under a Workers' Compensation plan.
32. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions not a result of a mental disorder.
33. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
34. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
35. Charges incurred for a hospital stay beginning on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted