

Humana Connect Silver 4600/6300 Plan with Children's Dental An HMO plan

Texas

This plan is available for purchase in the following counties: Bexar, Burnet, Fort Bend, Harris, Hays, McLennan, Montgomery, Travis and Williamson

About this plan

The Humana Connect Silver 4600/6300 Plan with Children's Dental is an easy-to-understand Health Maintenance Organization (HMO) health plan. You must choose a primary care physician (PCP) from our network of local healthcare providers who will refer you to in-network specialists or hospitals when necessary.

- ▶ The Humana Connect Silver 4600/6300 Plan with Children's Dental, an HMO plan, is a Qualified Health Plan offered by Humana Health Plan of Texas, Inc. - A Health Maintenance Organization.
- ▶ This plan provides all preventive services and includes all essential health benefits, like maternity and childbirth and pediatric dental.

Selecting a primary care physician (PCP) – When you apply for the Humana Connect Silver 4600/6300 Plan with Children's Dental, you'll select a PCP who will be your first point of contact for healthcare. Your PCP will work with you to coordinate your healthcare through a select group of doctors, specialists and hospitals in a local network. Together you and your PCP can make the best decisions to manage your health and well-being, which includes your PCP making referrals to specialists.

- ▶ To find a PCP in your area, visit **Humana.com**. Humana's easy-to-use Physician Finder Plus will help you locate a healthcare professional close to home.
 - If you live in Burnet, Hays, Travis, or Williamson County, your network is called Austin HMOx
 - If you live in McLennan County, your network is called Waco HMOx
 - If you live in Fort Bend, Harris, or Montgomery County, your network is called Houston HMOx
 - If you live in Bexar County, your network is called San Antonio HMOx

Who can apply for this plan – Any individual or family can apply for this plan. There are only three requirements: You must live in the U.S., you must be U.S. citizens or nationals (or lawfully present), and you cannot be currently incarcerated. (<http://www.healthcare.gov/marketplace/about/eligibility>)

Date the plan starts – Depending on when you enroll, your start date can be as early as the first of the following month after you apply. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. Coverage can begin as early as January 1, 2014.

Out-of-network coverage – There's no coverage for out-of-network providers except for emergency care as defined in your contract.



Humana Connect Silver 4600/6300 Plan with Children's Dental

How this plan works

	In-network	
	Individual	Family
The combined medical, children's vision care and children's dental care deductible – The amount of covered expenses you'll pay out of your pocket before this plan begins to pay for covered services	\$4,600	\$9,200
The prescription drug deductible – The amount you'll pay out of your pocket before this plan begins to pay for prescription drugs	\$1,500	\$3,000
The out-of-pocket maximum – The maximum amount you're required to pay toward the covered cost of your healthcare; includes deductibles, coinsurance and copays; does not include premium	\$6,300	\$12,600
! Important to know: › Family contracts have a family deductible and family out-of-pocket maximum. This means that the entire family deductible must be paid before coinsurance benefits are payable for any family member on the plan › Once you reach your out-of-pocket maximum, then this plan will pay 100% of all covered expenses › Copays do not accumulate toward the deductible, but they do accumulate to the out-of-pocket maximum › Deductibles and out-of-pocket maximum start over each new calendar year		
Coinsurance – The percentage of covered healthcare costs you have to pay	You pay 20% of covered expenses after you pay your deductible	
Lifetime maximum – The total amount this plan will pay for covered expenses in your lifetime	Unlimited	

Humana Connect Silver 4600/6300 Plan with Children's Dental

How this plan works

The details below provide a general idea of covered benefits for this plan, yet don't explain everything. To be covered, expenses must be medically necessary and listed as covered in the contract. The contract is a document that outlines the benefits, provisions, and limitations of the plan. Please refer to the contract for this plan to learn more about the actual terms and conditions of the plan. This plan also has limitations and services that are not covered. You should know about these. See page 7 for details.

In-network

Preventive care

This plan pays 100%

- › Includes well office visits, lab tests, X-rays, child immunizations, flu and pneumonia immunizations, Pap tests, mammograms, prostate screening, endoscopic services and more

! Important to know:

- › A PCP referral is not required for in-network OB/GYN services

Diagnostic office visits

This plan pays 100% after you pay a copay per visit:

- › Concentra, a national healthcare company and subsidiary of Humana Inc., is in-network for this plan when using an Urgent Care facility. To find a concentra location near you, visit **Concentra.com**

- \$25 for a primary care physician
- \$35 for a specialist
- \$35 for an Urgent Care visit at a Concentra location
- \$50 for an Urgent Care visit at a non-Concentra location

! Important to know:

- › Your PCP will coordinate your care with specialists as needed

Diagnostic lab and X-rays – Includes allergy testing

This plan pays 100% of the first \$500 per person per calendar year; then you pay 20% after you pay your deductible

- › Excludes advanced imaging, pulmonary function studies, cardiac catheterization, EKG, ECG and EEG – You pay 20% for these services after you pay your deductible

Emergency room

You pay 20% after you pay your deductible

Ambulance

You pay 20% after you pay your deductible

Hospital Stay

You pay 20% after you pay your deductible

- › Inpatient
 - Facility fee (e.g. hospital room)
 - Physician/surgeon fees
- › Outpatient
 - Facility fee (e.g. ambulatory surgery center)
 - Physician/surgeon fees

Maternity

You pay 20% after you pay your deductible

- › Prenatal and postnatal care
- › Delivery and other inpatient services

Transplants

You pay 20% when services are received from a Humana National Transplant Network provider after you pay your deductible

Humana Connect Silver 4600/6300 Plan with Children's Dental

How this plan works

In-network

Mental health (Mental illness, including mental illness with demonstrable organic disease, and chemical and alcohol dependency)

- › Includes inpatient and outpatient services

Benefit level is based upon the place of treatment (Inpatient, Outpatient, Clinic location)

Other medical services

- › Skilled nursing facility – up to 30 days per calendar year
- › Physical, occupational, cognitive, speech, audiology, cardiac, respiratory therapy, spinal manipulations, adjustments, and modalities - combined, up to 35 visits per calendar year
- › Home healthcare services - no visit limits apply
- › Hospice care - no visit limits apply
- › Hearing aids - up to 1 per ear every 36 months

You pay 20% after you pay your deductible

Prescription drugs

Important to know:

- › Prescriptions must be filled at CVS, Walmart, or Sam's Club pharmacies, or through mail-order service at **RightSourceRx.com**
 - If you use an out-of-network pharmacy, there is no coverage
 - You do not need to be a member of Sam's Club to have your prescription filled at Sam's Club pharmacies
 - Mail Order (up to 90 day supply): 2 times the retail copay
- › You pay a copay for each covered prescription fill or refill up to a 30-day supply
- › Prescription drug out-of-pocket costs, including prescription drug deductible, apply to the out-of-pocket maximum
- › To find out what drugs are included in this plan, visit **Humana.com** – once there, an easy-to-use Rx Tool will help you learn more about this plan's prescription drug benefits; the prescription drug plan name is **Rx5 Complete**

1. The covered drug expenses are first applied to the prescription drug deductible (unless a Level 1 or 2 drug – with these drugs you only have to pay your copay, no deductible)
2. Once you've met your deductible, then you pay a copay:
 - \$10 copay for Level 1: Covered preferred generic drugs (These drugs are covered before meeting your deductible)
 - \$20 copay for Level 2: Covered non-preferred generic drugs (These drugs are covered before meeting your deductible)
 - \$50 copay for Level 3: Covered preferred brand name drugs
 - 50% for Level 4: Covered non-preferred brand name drugs
 - 50% for Level 5: Covered self-administered specialty drugs (Some self-administered drugs are 40% when purchased from a preferred network specialty drug pharmacy like **RightSourceRx.com**)

Humana Connect Silver 4600/6300 Plan with Children's Dental

How this plan works

In-network

Children's vision care

You pay 50% after you pay your deductible

- › Exam with dilation as necessary (limit 1 per year)
- › Eyeglass lenses (limit 1 per year)
 - Single
 - Bifocal
 - Trifocal
 - Lens options – standard polycarbonate and/or standard scratch coating
- › Contact lenses (limit 1 per year)
 - Choose from a selection of covered contact lenses
 - Medically necessary contacts
- › Frames
 - Choose from a selection of covered frames
- › Low vision
 - Supplemental testing (limit 1 every 2 years)
 - Vision aids (limit 1 every 3 years) - excludes video magnification aids (1 every 5 years)

Important to know:

- › If you prefer contact lenses, this plan provides for a contact lens benefit in lieu of glass lenses; contact lens benefit is a one-time use per benefit frequency
- › If you buy a frame outside of the selection, this plan provides for a benefit up to the amount that would have been paid had you chosen a frame from the selection; additional discounts may be available with network providers
- › Children, up to age 19, are covered under this plan
- › The above services are not all inclusive; see the plan contract for more details

Humana Connect Silver 4600/6300 Plan with Children's Dental

How this plan works

In-network

Children's dental care

You pay 50% after you pay your deductible

Diagnostic and preventive services

- › Routine oral exams, periodontal exams, cleanings (limit 2 each per year)
- › Bitewing X-rays (limit 2 sets per year, excludes full mouth and panoramic)
- › Topical fluoride treatment (limit 2 per year)
- › Sealant

Minor restorative services and surgical

- › Prefabricated crowns (limit 1 per 5 years, primary teeth only)
- › Fillings
- › Simple oral surgery
 - Extractions

Major restorative services

- › Resin onlays, inlays and crowns (limit 1 per tooth per 5 years, permanent teeth only)
- › Root extraction

! Important to know:

- › There are more than 170,000 dentist locations in the Humana Dental PPO network; to find dentists in your area, visit **Humana.com**
- › Children, up to age 19, are covered under this plan

Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Your contract explains your share of the cost of services rendered by network providers. It may include a deductible, a set amount (copayment), and a percent of the cost (coinsurance).

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.
- There are primary care physician (PCP) selection requirements and specialist referral requirements.
- Primary care physician (PCP) referral is not required for network obstetrician and gynecologist services.

When you go to an out-of-network provider:

- There is no coverage for out-of-network providers, except for emergency care as defined in your contract.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana individual health plan listed above. It is designed for convenient reference. Consult the contract for a complete list of limitations and exclusions. The contract is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the contract. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

1. Services which require a primary care physician referral if a referral was not obtained;
2. Services provided by a non-network provider, except when:
 - a. Authorized by us;
 - b. A referral is obtained from a primary care physician; or
 - c. The following services are medically necessary to render emergency care;
 - i. Professional ambulance service;
 - ii. Services in a hospital emergency room; or
 - iii. Services in an urgent care center;
3. Services for care and treatment of non-covered procedures;
4. Services incurred before the effective date or after the termination date;
5. Services not medically necessary for diagnosis and treatment of a bodily injury or illness, except for the specified routine preventive services;
6. Charges for prophylactic services including, but not limited to, prophylactic mastectomy or any other services performed to prevent a disease process from becoming evident in the organ tissue at a later date;
7. Services which are experimental, investigational or for research purposes, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is experimental, investigational or for research purposes except as expressly provided in the contract. The fact that a service is the only available treatment for a condition may not make it eligible for coverage if we deem it to be experimental, investigational or for research purposes;
8. Complications directly related to a service that is not a covered expense under the contract because it was determined by us to be experimental, investigational or for research purposes or not medically necessary, except as expressly provided in the contract. Directly related means that the service occurred as a direct result of the experimental, investigational or for research purposes or not medically necessary service and would not have taken place in the absence of the experimental, investigational or for research purposes or not medically necessary service;
9. Charges in excess of the maximum allowable fee for the service;
10. Services exceeding the amount of benefits available for a particular service;
11. Services for any condition excluded by rider under the contract;
12. Services provided when the contract is past premium due date, and payment is not received, subject to the 31-day grace period;
13. Services for treatment of complications of non-covered procedures or services;
14. Services, except for emergency care, relating to a illness or bodily injury incurred as a result of the covered person:
 - a. Being intoxicated, as defined by applicable state law in the state in which the loss occurred; or
 - b. Being under the influence of illegal narcotics or controlled substance unless administered or prescribed by a healthcare practitioner;
15. Services relating to a illness or bodily injury as a result of:
 - a. Intentionally self-inflicted bodily harm or attempted suicide whether sane or insane, except for emergency care;
 - b. War or an act of war, whether declared or not;
 - c. Taking part in a riot;
 - d. Engaging in an illegal occupation; or
 - e. Any act of armed conflict, or any conflict involving armed forces or any authority;
16. Services:
 - a. For charges which are not authorized, furnished or prescribed by a healthcare practitioner or healthcare treatment facility;
 - b. For which no charge is made, or for which the covered person would not be required to pay if he/she did not have this insurance, unless charges are received from and reimbursable to the United States government, or any of its agencies as required by law;
 - c. Furnished by or payable under any plan or law through a government or any political subdivision, except Medicaid, unless prohibited by law which you or the covered person is not legally obligated to pay;
 - d. Furnished while a covered person is confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected illness or bodily injury;
 - e. For charges received from a healthcare practitioner over the rate we would pay for the least costly provider;
 - f. Which are not rendered or not substantiated in the medical records;
 - g. Provided by a family member or person who resides with the covered person;
 - h. Rendered by a standby healthcare practitioner, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary; or
 - i. Performed in association with a non-covered service.
17. Any charges, including healthcare practitioner charges, which are incurred if a covered person is admitted to a hospital on a Friday or Saturday unless:
 - a. The hospital admission is due to emergency care; and
 - b. Treatment or surgery is performed on that same day;
18. Hospital inpatient services when the covered person is in observation status;
19. Cosmetic services, or any complication therefrom;
20. Custodial care and maintenance care;
21. Ambulance services for routine transportation to, from or between medical facilities and/or a healthcare practitioner's office;
22. Elective caesarean section delivery;
23. Elective medical or surgical procedures except elective tubal ligation and vasectomy;
24. Elective medical or surgical abortion unless:
 - a. The pregnancy would endanger the life of the mother; or
 - b. The pregnancy is a result of rape or incest;
25. Reversal of sterilization;
26. Infertility services;
27. Sexual dysfunction;
28. Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems;
29. Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy; refractive keratoplasty; or any other surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in the contract;
30. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely unerupted impacted teeth, any oral or periodontal surgery and preoperative and post operative care, implants and related procedures, orthodontic procedures, and any dental services related to a bodily injury or illness except as expressly provided in the contract;
31. Pre-surgical/procedural testing duplicated during a hospital confinement;
32. Any treatment for obesity, regardless of any potential benefits for co-morbid conditions, including but not limited to:
 - a. Surgical procedures for morbid obesity;
 - b. Services or procedures for the purpose of treating an illness or bodily injury caused by, complicated by, or exacerbated by the obesity; or
 - c. Complications related to any services rendered for weight reduction;
33. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss surgery;
34. Treatment of nicotine habit or addiction, including but not limited to, nicotine patches, hypnosis, smoking cessation classes, tapes or electronic

- media except as eligible for coverage under Preventive Services;
35. Educational or vocational training or therapy, services, and schools including but not limited to videos and books;
 36. Foot care services including but not limited to:
 - a. Shock wave therapy of the feet;
 - b. Treatment of weak, strained, flat, unstable or unbalanced feet;
 - c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis except as expressly provided in the contract;
 - d. Tarsalgia, metatarsalgia or bunion treatment, except surgery which involves exposure of bones, tendons or ligaments;
 - e. Cutting of toenails, except removal of nail matrix except as expressly provided in the contract; and
 - f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless medically necessary because of diabetes or hammertoe;
 37. Hair prosthesis, hair transplants or implants;
 38. Hearing care that is routine, including but not limited to exams and tests, any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension, except as expressly provided in the contract;
 39. Services rendered in a premenstrual syndrome clinic or holistic medicine clinic;
 40. Transplant services except as expressly provided in the contract;
 41. Charges for growth hormones (drugs, medications or hormones to stimulate growth);
 42. Over the counter medical items or supplies that can be provided or prescribed by a healthcare practitioner but are also available without a written order or prescription, except for preventive services;
 43. Immunizations including those required for foreign travel for covered persons of any age except as expressly provided in the contract;
 44. Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull;
 45. Genetic testing, counseling or services;
 46. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/ examinations;
 47. Any expense incurred for services received outside of the United States except as required by law for emergency care services; Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental health;
 48. Services and supplies which are:
 - a. Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services;
 - b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
 - c. Specifically excluded is marriage counseling;
 49. No benefits will be provided for:
 - a. Immunotherapy for recurrent abortion;
 - b. Chemonucleolysis;
 - c. Biliary lithotripsy;
 - d. Home uterine activity monitoring;
 - e. Sleep therapy;
 - f. Light treatment for Seasonal Affective Disorder (S.A.D.);
 - g. Immunotherapy for food allergy;
 - h. Prolotherapy;
 - i. Cranial banding;
 - j. Hyperhydrosis surgery; and
 - k. Sensory integration therapy;
 50. Services or supplies provided in connection with an illness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as expressly provided in the contract. Without limiting this exclusion, this applies whether or not a covered person has Workers' Compensation coverage;
 51. Court-ordered mental health services;
 52. Spinal manipulations, adjustments, and modalities except as expressly provided in the contract;
 53. Charges for alternative medicine, including medical diagnosis, treatment and therapy. Alternative medicine services includes, but is not limited to:
 - a. Acupressure;
 - b. Acupuncture;
 - c. Aromatherapy;
 - d. Ayurveda;
 - e. Biofeedback;
 - f. Faith healing;
 - g. Guided mental imagery;
 - h. Herbal medicine;
 - i. Holistic medicine;
 - j. Homeopathy;
 - k. Hypnosis macrobiotic;
 - l. Massage therapy;
 - m. Naturopathy;
 - n. Ozone therapy;
 - o. Reflexotherapy;
 - p. Relaxation response;
 - q. Rolfing;
 - r. Shiatsu; and
 - s. Yoga;
 54. Private duty nursing other than for services rendered for Hospice care, Home healthcare or Skilled nursing;
 55. Living expenses; travel; transportation, except as expressly provided in the "Ambulance services" provision or "Transplants" provision in the "Your Contract Benefits" section of the contract; and
 56. Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner) including but not limited to:
 - a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
 - b. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
 - c. Personal hygiene equipment including bath/ shower chairs, transfer equipment or supplies or bed side commodes;
 - d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
 - e. Medical equipment including blood pressure monitoring devices, breast pumps, PUVA lights and stethoscopes;
 - f. Charges for any membership fees or program fees paid by a covered person, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or similar programs and any related material or products related to these programs;
 - g. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
 - h. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

Prescription Drug Exclusions

1. Growth hormones (medications, drugs or hormones to stimulate growth) for idiopathic short stature;
2. Growth hormones, (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by us;
3. Drugs which are not included on the drug list;
4. Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or certain other inherited metabolic diseases and amino acid-based elemental formulas as expressly provided in the contract;
5. Nutritional products;
6. Fluoride supplements;
7. Minerals;
8. Herbs and vitamins;
9. Legend drugs which are not deemed medically necessary by us;
10. Any drug prescribed for an illness or bodily injury not covered under the contract;
11. Any drug prescribed for intended use other than for:
 - a. Indications approved by the FDA; or
 - b. Off-label indications recognized through peer-reviewed medical literature;
12. Any amount exceeding the default rate;
13. Any drug, medicine or medication that is either:
 - a. Labeled "Caution-limited by Federal law to investigational use"; or
 - b. Experimental, investigational or for research purposes, even though a charge is made to the covered person;
14. Allergen extracts;
15. The administration of covered medication(s);
16. Therapeutic devices or appliances, except as expressly provided in the contract, including but not limited to:
 - a. Hypodermic needles and syringes except needles and syringes for use with insulin, and self-administered injectable drugs whose coverage is approved by us;
 - b. Support garments;
 - c. Test reagents;
 - d. Mechanical pumps for delivery of medication; and
 - e. Other non-medical substances;
17. Anabolic steroids;
18. Anorectic or any drug used for the purpose of weight control;
19. Abortifacients (drugs used to induce abortions);
20. Any drug used for cosmetic purposes, including but not limited to:
 - a. Tretinoin, e.g. Retin A, except if the covered person is under the age of 45 or is diagnosed as having adult acne;
 - b. Dermatologicals or hair growth stimulants; or
 - c. Pigmenting or de-pigmenting agents, e.g. Solaquin;
21. Contrary to any other provisions of the contract,

- we may decline coverage or, if applicable, exclude from the Drug List any and all prescriptions, including new indications for an existing prescription, until the conclusion of a review period not to exceed 6 following FDA approval for the use and release of the prescription, including new indications for an existing prescription into the market;
22. Any drug or medicine that is:
 - a. Lawfully obtainable without a prescription (over the counter drugs), except insulin; or drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a healthcare practitioner; or
 - b. Available in prescription strength without a prescription;
 23. Compounded drugs in any dosage form except for chemotherapy or when prescribed for pediatric use for children up to 19 years of age;
 24. Progesterone crystals or powder in any compounded dosage form;
 25. Infertility services including medications;
 26. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
 27. Any drug, medicine or medication that is consumed or injected at the place where the prescription is given or dispensed by the healthcare practitioner;
 28. Drug delivery implants;
 29. Treatment for Onychomycosis (nail fungus);
 30. Prescriptions that are to be taken by or administered to the covered person, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
 - a. Hospital;
 - b. Skilled nursing facility; or
 - c. Hospice facility;
 31. Injectable drugs, including but not limited to:
 - a. Immunizing agents;
 - b. Biological sera;
 - c. Blood;
 - d. Blood plasma;
 - e. Self-administered injectable drugs or specialty drugs for which coverage is not approved by us; or
 - f. Flu and pneumonia vaccines, except as expressly provided in the contract;
 32. Prescription refills:
 - a. In excess of the number specified by the healthcare practitioner; or
 - b. Dispensed more than one year from the date of the original order;
 33. Any portion of a prescription or refill that exceeds a 90-day supply when received from either a mail-order pharmacy or from a retail pharmacy that participates in our program which allows a covered person to receive a 90-day supply of a prescription or refill;
 34. Any portion of a prescription or refill that exceeds a 30-day supply when received from a retail pharmacy that does not participate in our program which allows a covered person to receive a 30-day supply of a prescription or refill;
 35. Any portion of a specialty drug or self-administered injectable drug that exceeds a 30-day supply;
 36. Any portion of a drug for which preauthorization or step therapy is required and not obtained;
 37. Any drug for which a charge is customarily not made;
 38. Any portion of a prescription or refill that:
 - a. Exceeds our drug specific dispensing limit (i.e. IMITREX);
 - b. Is dispensed to a covered person whose age

- is outside the drug specific age limits defined by us;
- c. Is refilled early, as defined by us; or
 - d. Exceeds the duration-specific dispensing limit;
39. Any drug, medicine or medication received by the covered person:
 - a. Before becoming covered under the benefit; or
 - b. After the date the covered person's coverage under the contract has ended;
 40. Any costs related to the mailing, sending or delivery of prescription drugs;
 41. Any intentional misuse of the benefit, including prescriptions purchased for consumption by someone other than the covered person;
 42. Any prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
 43. Any drug, medication, or supply to eliminate or reduce a dependency on or addiction to tobacco and tobacco products except as eligible for coverage under Preventive Services;
 44. Any amount the covered person paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription.

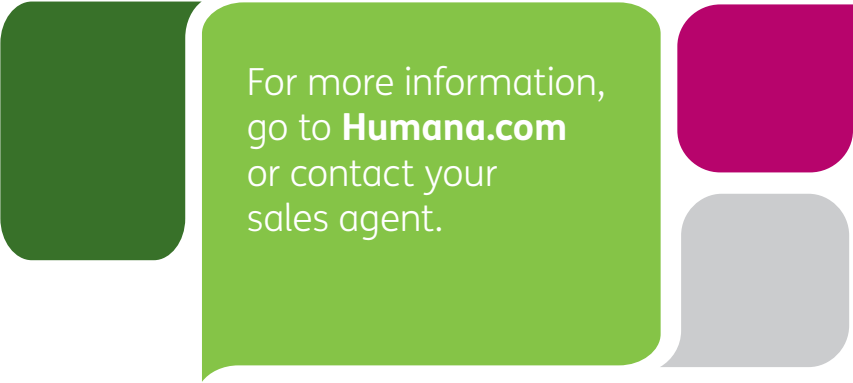
Pediatric Dental Care Limitations and Exclusions

1. Any expense arising from the completion of forms;
2. Any expense due to a covered person's failure to keep an appointment;
3. Any expense for a service we consider cosmetic, unless it is due to an accidental dental injury;
4. Expenses incurred for:
 - a. Any type of implant and all related services, including crowns or the prosthetic device attached to it;
 - b. Removal of implants;
 - c. Precision or semi-precision attachments;
 - d. Overdentures and any endodontic treatment associated with overdentures;
 - e. Other customized attachments;
 - f. Any services for 3D imaging (cone beam images);
 - g. Temporary and interim dental services; or
 - h. Additional charges related to materials or equipment used in the delivery of dental care;
5. Charges for services rendered by a family member or person who resides with the covered person;
6. Any service related to:
 - a. Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth;
 - b. Restoration or maintenance of occlusion;
 - c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction; or
 - e. Bite registration or bite analysis;
7. Infection control, including but not limited to, sterilization techniques;
8. Expenses incurred for services performed by someone other than a dentist, except for scaling and teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards;
9. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist;
10. Prescription drugs or pre-medications, whether

- dispensed or prescribed;
11. Any service that:
 - a. Is not eligible for benefits based on the clinical review;
 - b. Does not offer a favorable prognosis;
 - c. Does not have uniform professional acceptance; or
 - d. Is deemed to be experimental or investigational in nature;
 12. Orthodontic services, unless specified in the "Pediatric Dental Care Covered Expenses" or "Schedule of Benefits" provisions;
 13. Repair and replacement of orthodontic appliances;
 14. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning;
 15. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance;
 16. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures; or
 17. Services provided by a non-network provider.

Pediatric Vision Care Limitations and Exclusions

1. Orthoptic or vision training and any associated supplemental testing;
2. Two or more multiple pair of glasses, in lieu of bifocals or trifocals;
3. Medical or surgical treatment of the eye, eyes or supporting structure;
4. Any services and/or materials required by an employer as a condition of employment;
5. Safety lenses and frames;
6. Contact lenses, when benefits for frames and lenses are received;
7. Oversized 61 and above lens or lenses;
8. Cosmetic items;
9. Any services or materials not listed in the "Pediatric Vision Care Benefit" section or "Schedule of Benefits";
10. Expenses for missed appointments;
11. Any charge from a providers' office to complete and submit claim forms;
12. Treatment relating to or caused by disease;
13. Non-prescription materials or vision devices;
14. Costs associated with securing materials;
15. Pre- and post-operative services;
16. Orthokeratology;
17. Routine maintenance of materials;
18. Refitting or change in lens design after initial fitting;
19. Artistically painted lenses;
20. Premium lens options;
21. Pediatric vision care not obtained from a network provider designated by us;
22. Online purchase of complete pair of eyeglasses when not purchased through the network provider designated by us; or
23. Services provided by a non-network provider.



For more information,
go to **Humana.com**
or contact your
sales agent.

Offered by Humana Health Plan of Texas, Inc. - A Health Maintenance Organization, referred to herein as Humana. Applications are subject to approval. Limitations and exclusions apply.

This document contains a general summary of covered benefits, exclusions, and limitations. Please refer to the contract 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 contract will apply.

Humana[®]