# HUMANA HEALTH PLAN, INC.: TX SG NPOS 14

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

**Coverage Period: Beginning on or after 01/01/2014**
**Coverage For:** Individual + Family | **Plan Type:** NPOS

**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 1-866-4ASSIST (427-7478).

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Network:<br>**$1,000 Individual / $2,000 Family**<br>Non-Network:<br>**$3,000 Individual / $6,000 Family**<br>Doesn't apply to prescription drugs and preventive services.<br>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 3 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 3 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses** | Yes. For Network providers<br>**$4,000 Individual / $8,000 Family**<br>For Non-Network providers<br>**$12,000 Individual / $24,000 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 | 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 3 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 1-866-4ASSIST (427-7478)** for a list of Network providers. | If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 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 7. 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 a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-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 | $25 copay/visit | 50% coinsurance | ———none——— |
| | Specialist visit | $40 copay/visit | 50% coinsurance | ———none——— |
| | Other practitioner office visit | Chiropractor:<br>$40 copay/visit | Chiropractor:<br>50% coinsurance | Chiropractor:<br>40 visits per calendar year, includes manipulations, adjustments<br>For non-network, 10 visits per calendar year, includes manipulations, adjustments |
| | Preventive care / screening / immunization / endoscopic / preventive care (child) / screening (child) / immunizations (child) | No Charge | 50% coinsurance | limited coverage for preventive care |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | 50% coinsurance | Cost share may vary based on where service is performed |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply<br>Cost share may vary based on where service is performed |

| 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**<br><br>**More information about <u>prescription drug coverage</u> is available at www.humana.com.** | Level 1 – Lowest cost generic and brand-name drugs | $10 copay (Retail)<br>$25 copay (Mail Order) | 30% coinsurance (Retail)<br>30% coinsurance (Mail Order) | Preauthorization may be required, penalties may apply.<br>30 day supply (Retail)<br>90 day supply (Mail Order) |
| | Level 2 – Higher cost generic and brand-name drugs | $30 copay (Retail)<br>$75 copay (Mail Order) | See Level 1 for Non-Network benefit | See Level 1 for Limitations and Exceptions |
| | Level 3 – Generic and brand-name drugs with higher cost than Level 2 | $50 copay (Retail)<br>$125 copay (Mail Order) | See Level 1 for Non-Network benefit | See Level 1 for Limitations and Exceptions |
| | Level 4 – Highest cost drugs | 25% coinsurance (Retail)<br>25% coinsurance (Mail Order) | See Level 1 for Non-Network benefit | See Level 1 for Limitations and Exceptions |
| | Specialty drugs | 35% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply<br>25% coinsurance when filled via a preferred network specialty pharmacy |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | $250 copay/visit | $250 copay/visit | Copayment waived if admitted |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ——————none—————— |
| | Urgent care | $100 copay/visit | 50% 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) | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Physician/surgeon fee | 20% coinsurance | 50% coinsurance | ———none——— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25 copay/visit | 50% coinsurance | ———none——— |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Substance use disorder outpatient services | $25 copay/visit | 50% coinsurance | ———none——— |
| | Substance use disorder inpatient services | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | 50% coinsurance | ———none——— |
| | Delivery and all inpatient services | 20% coinsurance | 50% 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 need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Rehabilitation services | $40 copay/visit | 50% coinsurance | Preauthorization may be required, penalty may apply<br>40 visits per calendar year, includes manipulations, adjustments<br>For non-network, 10 visits per calendar year, includes manipulations, adjustments<br>Any limits for Habilitation services and Rehabilitation services are combined. |
| | Habilitation services | $40 copay/visit | 50% coinsurance | Preauthorization may be required, penalty may apply<br>40 visits per calendar year, includes manipulations, adjustments<br>For non-network, 10 visits per calendar year, includes manipulations, adjustments<br>Any limits for Habilitation services and Rehabilitation services are combined. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply<br>60 day limit per calendar year |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Hospice service | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| **If your child needs dental or eye care** | Eye exam | 50% coinsurance | 50% coinsurance | 1 every 12 months |
| | Glasses | 50% coinsurance | 50% coinsurance | 1 frame every 12 months<br>1 pair of lenses every 12 months |
| | Dental check-up | 50% coinsurance | 50% coinsurance | Two every year up to age 19 |

## 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.)**

- Acupuncture
- Bariatric surgery for morbid obesity
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## 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:
Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478)
Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Insurance, PO Box 149104, Austin, TX 78714-9104, Phone: 512-463-6169 or 800-578-4677
Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Health Assistance Program, Department of Insurance, Mail Code 111-1A, PO Box 149091, Austin, TX 78714, Website: www.texashealthoptions.com, Email: chap@tdi.state.tx.us, Phone: 855-839-2427

## 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 meet the minimum value standard for the benefits it provides.**

*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** $5,383.65
- **Patient pays** $2,156.35

**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 | $1,000.00 |
| Copays | $45.21 |
| Coinsurance | $1,111.14 |
| Limits or exclusions | $0.00 |
| **Total** | **$2,156.35** |

## Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,981.74
- **Patient pays** $1,418.26

**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 | $0.00 |
| Copays | $1,400.20 |
| Coinsurance | $0.00 |
| Limits or exclusions | $18.06 |
| **Total** | **$1,418.26** |

# 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?

✗ **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?

✗ **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?

✓ **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?

✓ **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.

**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 **1-866-4ASSIST (427-7478)**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Network:<br>**$2,000 Individual / $4,000 Family**<br>Non-Network:<br>**$6,000 Individual / $12,000 Family**<br>Doesn't apply to prescription drugs and preventive services.<br>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 3 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 3 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses** | Yes. For Network providers<br>**$6,350 Individual / $12,700 Family**<br>For Non-Network providers<br>**$19,050 Individual / $38,100 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 | 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 3 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 1-866-4ASSIST (427-7478)** for a list of Network providers. | If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 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 7. 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 a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-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 | 50% coinsurance | ———none——— |
| | Specialist visit | $75 copay/visit | 50% coinsurance | ———none——— |
| | Other practitioner office visit | Chiropractor: $75 copay/visit | Chiropractor: 50% coinsurance | Chiropractor:<br>40 visits per calendar year, includes manipulations, adjustments<br>For non-network, 10 visits per calendar year, includes manipulations, adjustments |
| | Preventive care / screening / immunization / endoscopic / preventive care (child) / screening (child) / immunizations (child) | No Charge | 50% coinsurance | limited coverage for preventive care |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | 50% coinsurance | Cost share may vary based on where service is performed |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply<br>Cost share may vary based on where service is performed |

| 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**<br><br>**More information about prescription drug coverage is available at www.humana.com.** | Level 1 – Lowest cost generic and brand-name drugs | $10 copay (Retail)<br>$25 copay (Mail Order) | 30% coinsurance (Retail)<br>30% coinsurance (Mail Order) | Preauthorization may be required, penalties may apply.<br>30 day supply (Retail)<br>90 day supply (Mail Order) |
| | Level 2 – Higher cost generic and brand-name drugs | $45 copay (Retail)<br>$112.5 copay (Mail Order) | See Level 1 for Non-Network benefit | See Level 1 for Limitations and Exceptions |
| | Level 3 – Generic and brand-name drugs with higher cost than Level 2 | $75 copay (Retail)<br>$187.5 copay (Mail Order) | See Level 1 for Non-Network benefit | See Level 1 for Limitations and Exceptions |
| | Level 4 – Highest cost drugs | 25% coinsurance (Retail)<br>25% coinsurance (Mail Order) | See Level 1 for Non-Network benefit | See Level 1 for Limitations and Exceptions |
| | Specialty drugs | 35% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply<br>25% coinsurance when filled via a preferred network specialty pharmacy |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | ———none——— |
| **If you need immediate medical attention** | Emergency room services | $350 copay/visit | $350 copay/visit | Copayment waived if admitted |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ———none——— |
| | Urgent care | $100 copay/visit | 50% 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) | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Physician/surgeon fee | 20% coinsurance | 50% coinsurance | ——none—— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $30 copay/visit | 50% coinsurance | ——none—— |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Substance use disorder outpatient services | $30 copay/visit | 50% coinsurance | ——none—— |
| | Substance use disorder inpatient services | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | 50% coinsurance | ——none—— |
| | Delivery and all inpatient services | 20% coinsurance | 50% 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 need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Rehabilitation services | $75 copay/visit | 50% coinsurance | Preauthorization may be required, penalty may apply<br>40 visits per calendar year, includes manipulations, adjustments<br>For non-network, 10 visits per calendar year, includes manipulations, adjustments<br>Any limits for Habilitation services and Rehabilitation services are combined. |
| | Habilitation services | $75 copay/visit | 50% coinsurance | Preauthorization may be required, penalty may apply<br>40 visits per calendar year, includes manipulations, adjustments<br>For non-network, 10 visits per calendar year, includes manipulations, adjustments<br>Any limits for Habilitation services and Rehabilitation services are combined. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply<br>60 day limit per calendar year |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| | Hospice service | 20% coinsurance | 50% coinsurance | Preauthorization may be required, penalty may apply |
| **If your child needs dental or eye care** | Eye exam | 50% coinsurance | 50% coinsurance | 1 every 12 months |
| | Glasses | 50% coinsurance | 50% coinsurance | 1 frame every 12 months<br>1 pair of lenses every 12 months |
| | Dental check-up | 50% coinsurance | 50% coinsurance | Two every year up to age 19 |

## 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.)**

- Acupuncture
- Bariatric surgery for morbid obesity
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
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- 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## 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:
Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478)
Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Insurance, PO Box 149104, Austin, TX 78714-9104, Phone: 512-463-6169 or 800-578-4677
Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Health Assistance Program, Department of Insurance, Mail Code 111-1A, PO Box 149091, Austin, TX 78714, Website: www.texashealthoptions.com, Email: chap@tdi.state.tx.us, Phone: 855-839-2427

## 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 meet the minimum value standard for the benefits it provides.**

*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.

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See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,583.65
- **Patient pays** $2,956.35

**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 | $2,000.00 |
| Copays | $45.21 |
| Coinsurance | $911.14 |
| Limits or exclusions | $0.00 |
| **Total** | **$2,956.35** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,555.48
- **Patient pays** $1,844.52

**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 | $0.00 |
| Copays | $1,826.46 |
| Coinsurance | $0.00 |
| Limits or exclusions | $18.06 |
| **Total** | **$1,844.52** |

# 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?

✗ **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?

✗ **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?

✓ **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?

✓ **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.

DENTALSELECT.

# Dental Summary

Toll Free Phone: 800-999-9789 Toll Free Fax: 888-998-8703 DentalSelect.com

Summary of Benefits For:

## Neos Consulting Group LLC

**90th R&C**

| | Indemnity Classic Plan | |
|---|---|---|
| | Platinum Network | |
| **PREVENTIVE** | **Contracted Dentist** | **Non-Contracted Dentist** |
| *Routine exams, cleanings (2 per year), topical fluoride, x-rays, space maintainers, sealants* | **100%** | **100% of R&C** |
| **BASIC** | | |
| *Composite fillings, extractions, oral surgery, endodontics, periodontics* | **80%**<br>No Waiting Period | **80% of R&C** |
| **MAJOR** | | |
| *Crowns, bridges, dentures* | **50%**<br>No Waiting Period | **50% of R&C** |
| **ORTHODONTICS** | | |
| *Children under 19* | **20% Discount** | **No Benefit** |
| *Waiting Period* | No Waiting Period | |
| *Lifetime Maximum* | **No Maximum** | |
| *All Members* | **20% Discount** | |
| **MAXIMUM BENEFIT** | | |
| *Applies to Preventive, Basic and Major Services* — *Benefit Period is:* *Per Calendar Year* | **$1500.00** | |
| **DEDUCTIBLE** | | |
| *Applies to Basic and Major Services* — *Per Benefit Period* | | |
| *Per Person:* | **$50.00** | **$50.00** |
| *Family Maximum:* | **$150.00** | **$150.00** |
| **SPECIALISTS** | | |
| *Endodontists, Oral Surgeons, Pediatric, Periodontists, Prosthodontists* | **Contracted Specialist payment:**<br>1) You receive a 20% discount off the Specialist fee<br>2) Plan pays according to the Reasonable and Customary fees<br>3) Member pays the difference between plan payment and discounted Specialist fee<br>**Non-contracted Specialist payment:**<br>Paid the same as non-contracted dentists | |

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The benefits illustrated are in summary form only. They should not be construed as complete in and of themselves. They are only for comparison and in the case of a discrepancy, the plan documents apply. Please refer to the Group Certificate Booklet for a complete description of benefits, limitations and exclusions.

Dental Notes For:

**Neos Consulting Group LLC**

## Network Access

**Texas**

Four networks are utilized in Texas, the Dental Select Signature, Platinum and Gold Networks, and the Connection Dental Network. Access to Connection Dental Network is only allowed if enrolled on a co-insurance plan using the Dental Select Signature or Platinum Networks. Co-pay plans affliated with either the Gold or Platinum networks, and co-insurance plans using the Gold Network utilize the Dental Select Networks only.

Dental Select participating general dentists accept the Platinum, Signature, or Gold fee schedule as payment in full. Connection Dental participating general dentists accept the Connection Dental Fee Schedule as payment in full.

**Contracted Specialists - Texas**

Connection Dental Network: Services rendered by Connection Dental Participating Specialist will be reimbursed according to the Connection Dental fee schedule as payment in full. Orthodontics: The maximum charge allowed is $3,800

Dental Select Platinum or Signature Networks: Services rendered by a Dental Select Participating Specialist will be reimbursed as follows.

1) You receive a 20% discount off the Specialist's fee.
2) Plan pays according to the Reasonable and Customary fees.*
3) Member is responsible for the difference between the Plan's payment & the discounted Specialist's fee

*Co insurance plans using the Gold Network - After a 20% discount, plan pays according to the General Dentist fee schedule.

**Nevada Members – Diversified Dental Services**

Contracted General Dentists and Specialists: Benefits are paid off of the Diversified fee schedule there is no balance billing.

**Utah**

Dental Select participating general dentists accept the Signature, Platinum or Gold fee schedule as payment in full.

**Contracted Specialists - Utah**

Dental Select Signature or Platinum Networks: Services rendered by a Dental Select Participating Specialist will be reimbursed as follows.

1) You receive a 20% discount off the Specialist's fee.
2) Plan pays according to the Reasonable and Customary fees.*
3) Member is responsible for the difference between the Plan's payment & the discounted Specialist's fee.

*Co insurance plans using the Gold Network - After a 20% discount, plan pays according to the General Dentist fee schedule.

Co-Pay Plans - See Schedule of co-payments for patient responsibility

**Other States – Connection Dental**

Contracted General Dentists and Specialists: Benefits are paid off of the Connection Dental fee schedule; there is no balance billing.

Orthodontics: The maximum charge allowed is $3,800

## Plan Notes

**Indemnity**

IN NETWORK: General Dentists: All payments made by the plan are based on the Platinum or Connection Dental Fee Schedule. Platinum Network Contracted Specialists: Plan pays According to the Reasonable and Customary Fees. OUT OF NETWORK: Dental Select will allow up to the reasonable and customary charge for the dental procedures and services after the required deductible amount, as shown. Charges above the plan payment are the patient's responsibility.
DISCOUNT: Discount only; no benefit will be paid.

This summary of benefits is current as of 08/12/2013. To verify up to date benefits, please contact Dental Select Member Services (1-800-999-9789) or refer to your current Certificate of Insurance.

DentalSelect.

# Vision Summary

Toll Free Phone: 800-999-9789 Toll Free Fax: 888-998-8703 DentalSelect.com

Summary of Benefits For:

## Neos Consulting Group LLC

| | Access Choice Vision 7 | |
|---|---|---|
| | In-Network | Out-of-Network |
| | (Member Cost) | (Reimbursement) |
| **Exam with Dilation as Necessary** | $10 | Up to $45 |
| **Contact Lens Options** | | |
| *Standard fit and follow-up* | Up to $55 | N/A |
| *Premium fit and follow-up* | 10% off Retail | N/A |
| **Standard Plastic Lenses** | | |
| *Single Vision* | $25 | Up to $40 |
| *Bifocal* | $25 | Up to $60 |
| *Trifocal* | $25 | Up to $80 |
| **Frames** | | |
| *Any frame at provider location* | $0 CoPay, $130 allowance; 20% off balance over $130 | Up to $45 |
| **Lens Options** | | N/A |
| *UV Coating* | $0 | |
| *Tint* *(Solid and Gradient)* | $0 | |
| *Standard Scratch-Resistance* | $0 | |
| *Standard Polycarbonate* | $0 | |
| *Standard Progressive* *(Add-on to Bifocal)* | $0 | |
| *Standard Anti-Reflective* | $45 | |
| *Other Add-ons and Services* | 20% Discount | |
| **Contact Lenses** | **Declining Balance Allowance** | |
| *Conventional* | $0 CoPay: $150 Allowance; 15% off balance over $150 | Up to $150 |
| *Disposables* | $0 CoPay: $150 Allowance; member responsible for balance over $150 | Up to $150 |
| *Medically Necessary* | $0 CoPay: Paid in Full | Up to $210 |
| **Laser Correction** (US Laser Network) | | |
| *Lasik or PRK* | 15% off retail price -or- 5% off promotional price | Not Covered |
| **Frequency** | | |
| *Examination* | Once every 12 months | Once every 12 months |
| *Frame* | Once every 12 months | Once every 12 months |
| *Lenses or Contact Lenses* | Once every 12 months | Once every 12 months |

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Vision Notes For:

**Neos Consulting Group LLC**

## Plan Notes

Members will receive a 20% discount on items not covered by the plan at network providers. This discount may not be combined with any other discounts or promotional offers and does not apply to Eyemed Provider's professional services or contact lenses. retail prices may vary by location.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance except for contact lens materials, when applicable. Lost or broken materials are not covered.

When enrolled on the Value Vision Plan, complete pair of eyeglasses (frames, lenses, & lens options) must be purchased in the same transaction to receive full discount. If purchased separately, members receive 20% off retail price.

When enrolled on the Classic or Choice vision plans, Members receive a 40% discount off complete eyeglass purchases and a 15% discount off conventional contact lenses at unlimited frequency after the initial benefit has been used. After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at www.eymedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6

This summary of benefits is current as of 08/12/2013. To verify up to date benefits, please contact Dental Select Member Services (1-800-999-9789) or refer to your current Certificate of Insurance.

Lincoln Financial Group®

## Group Life Insurance

**Life and AD&D**

SUMMARY OF BENEFITS

**Sponsored by:** **Neos Consulting Group** **Effective date:** **9/1/11**

| **Life Benefit** | **Employee** |
|---|---|
| Amount | Flat $50,000 |
| Minimum Amount | $50,000 |
| Maximum Amount | $50,000 |
| Guarantee Issue | $50,000 |
| **AD&D Benefit** | **Employee** |
| Amount | Flat $50,000 |
| Minimum Amount | $50,000 |
| Maximum Amount | $50,000 |
| Guarantee Issue | $50,000 |
| **Benefit Reduction** | **Employee** |
| Benefits will reduce: | 35% at age 65<br>An additional 25% of the original amount at age 70; and<br>An additional 15% of the original amount at age 75<br>Benefits terminate at retirement |
| **Additional Benefits** | **Employee** |
| See Definitions page for: | Accelerated Death Benefit |
| See Definitions page for: | Seat Belt, Airbag, and Common Carrier |
| See Definitions page for: | Conversion |
| **Eligibility** | **Employee** |
| | All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work. |

(Please see other side)

| Definitions | |
|---|---|
| **Accelerated Death Benefit** | Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option. |
| **AD&D** | Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable. |
| **Conversion** | If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination. |
| **Guarantee Issue** | For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance and it will be provided at your own expense. |
| **Seat Belt, Airbag, Common Carrier** | If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate. |
| **Term Life** | Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product. |
| **Exclusion: Suicide** | Benefits will not be paid if the death results from suicide within two years after coverage is effective. May apply if employee contributes toward the premium. |
| **Additional Benefits** | |
| ***BeneficiaryConnect*** SM | Support services for beneficiaries who have experienced a loss. |
| ***TravelConnect*** SM | Travel assistance services for employees and eligible dependents traveling more than 100 miles from home. |

**For assistance or additional information**
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

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