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ISLAND FOUNDATION

DEDICATED TO EXCELLENCE AT SEASHORE CHARTER SCHOOLS

The following guide is intended to provide brief information and pricing for the employee benefits offered by our company. If further information is needed, please contact Human Resources.

BENEFITS ENROLLMENT GUIDE

September 1, 2023 to August 31, 2024

Benefits Overview

Island Foundation is proud to offer a diverse benefits package to eligible employees. The package is briefly summarized in this booklet.

- All Full-time employees working 30 hours or more hours are eligible to enroll in the benefit plans offered.
- Eligible employees have the opportunity to enroll their legal dependents in benefits that they are eligible for, and premiums for those elected benefits will be deducted through Island Foundation payroll on a pre-tax basis, if elected.

New Hire Eligibility

As a new employee of Island Foundation, you are eligible for benefits on the 1st of the month following 30 days of hire.

Dependent Eligibility

For all benefits, eligible dependents are your legal spouse and children up to age 26. This includes common-law marriage, step children, adopted children and legal guardianship. Children over the age of 26 are eligible to remain on a parent's plan if they have been medically certified as disabled by reason of mental or physical handicap.

Benefit Election Changes

Elections made at initial eligibility will remain in effect until the next open enrollment period, which is currently September, unless you or your family experience a qualifying event. The following are common qualifying events:

- Marriage, divorce, legal separation, death
- Birth, adoption or guardianship placement, court order
- Loss or gain of other coverage

Should you have a qualifying event you must contact Human Resources within 30 days of the event to be eligible to make any benefit changes. If the 30-day window is missed you will have to wait until the next open enrollment.

Insurance Company Contact Information

Medical, Dental & Vision Insurance:

Humana	www.humana.com	1-866-427-7478

Agent Contact Information

Keetch & Associates Insurance Agency:

Phone: (361) 883-3803	Mailing: P O Box 3280 Corpus Christi, Tx 78463
Fax: (361) 883-3894	Physical: 1718 Santa Fe Corpus Christi, Tx 78404

Service Representatives:

- Tiffany Pharis, MBA, ACSR, HIA, SGS
  Life & Health Department Manager
  tpharis@keetchins.com
- Tina Trusty, Customer Service Representative
  ttrusty@keetchins.com
- Cris Dyer, Customer Service Representative
  cdyer@keetchins.com

Keetch & Associates is a full-service agency, we understand that you do not have the time to sit on hold to speak to the insurance company, so we have the staff available to work as your liaison and reach out to the insurance company to assist you with your insurance needs. You may contact our service representatives for the following reasons:

- **Claims Questions – Please have the date of service, provider name and charged amount for the service.**
- **New Insurance ID Card – Have the employee's member ID or SSN and a current mailing address available.**
- **Name or Address Correction/Change – Email a completed change form indicating the requested change.**
- **Benefit or Eligibility Questions - Have the employee member ID or SSN available.**
- **Wellness Benefits – We will assist you in accessing and utilizing available Wellness programs.**
- **You must contact your Human Resource Department in order to add or remove dependents or if you have questions regarding payroll deductions.**

DISCLAIMER:

All information provided in this booklet is FOR INFORMATIONAL PURPOSES ONLY.

The text contained in this Guide was taken from various benefit summaries. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In the event of a discrepancy between this Guide and the actual plan documents, the plan documents provided by the carrier will always prevail.

All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Guide, please contact your Human Resource Department.

PLEASE NOTE: This handout only contains a summary of the available benefits. Please refer to the plan documents provided by the insurance company for full plan descriptions, including policy limitations and exclusions.

Medical and Prescription Drugs

Humana	TX Smpcty NPOS 16 Opt. 14	
	In-Network	**Out-Network**
Services		
Physician Visit	$40 PCP / $100 Spec.	50% after Deductible
Virtual Visit	$40 Copay	Not covered
Preventive Care	No Charge	50% after Deductible
Emergency Room	$600 Copay **(Only for true life-threatening emergencies, copay waived if admitted)**	
Urgent Care	$125 Copay/visit	50% after Deductible
Hospitalization	$2,000 Copay/First 3 days	50% after Deductible
Coinsurance	100%	50%
Diagnostic test/Imaging • **(x-ray, blood work)** • **(CT/PET/MRI)**	No Charge $600 Copay	50% after Deductible 50% after Deductible
Deductible • **Individual** • **Family**	$0 $0	$5,000 $10,000
Out of Pocket Maximum • **Individual** • **Family**	$6,500 $13,000	$19,500 $39,000
Prescription Drugs • **Level 1** • **Level 2** • **Level 3** • **Level 4**	$10 $45 $90 25%	50% additional charge after applicable Copay

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.groupcertificate.humana.com or by calling 866-4ASSIST (427-7478). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $0 individual / $0 family; Non-Network Providers: $5,000 individual / $10,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Network Providers: Not Applicable. Non-Network Providers: Yes. Emergency Room Care	This plan does not have a network deductible. This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $6,500 individual / $13,000 family; For non-network providers: $19,500 individual / $39,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services, non-network transplant, non-network prescription drugs, non-network specialty drugs, non-network immune effector cell therapy.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.humana.com/directories or call 866-4ASSIST (427-7478) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Telehealth or telemedicine services: $40 copay/office visit Primary care visit: $40 copay/office visit	Telehealth or telemedicine services: 50% coinsurance Primary care visit: 50% coinsurance	None
	Specialist visit	$100 copay/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	Imaging: Preauthorization may be required - if not obtained, penalty will be 50%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	$600 copay/visit	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.humana.com/2023-Rx4/	Level 1 - Low-cost generic and brand-name drugs	(Retail) $10 copay/prescription (Mail Order) $25 copay/prescription	(Retail) 30% coinsurance, after $10 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $25 copay/prescription; deductible does not apply	(Retail) 30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug. (Mail Order) 90 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug.
	Level 2 - Higher-cost generic and brand-name drugs	(Retail) $45 copay/prescription (Mail Order) $112.50 copay/prescription	(Retail) 30% coinsurance, after $45 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $112.50 copay/prescription; deductible does not apply	
	Level 3 - High-cost, mostly brand-name drugs	(Retail) $90 copay/prescription (Mail Order) $225 copay/prescription	(Retail) 30% coinsurance, after $90 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $225 copay/prescription; deductible does not apply	
	Level 4 - Highest-cost drugs	(Retail) 25% coinsurance (Mail Order) 25% coinsurance	(Retail) 30% coinsurance, after 25% coinsurance; deductible does not apply (Mail Order) 30% coinsurance, after 25% coinsurance; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Specialty drugs	Preferred network specialty pharmacy: 25% coinsurance Network specialty pharmacy: 25% coinsurance	50% coinsurance; deductible does not apply	30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$2,000 copay/visit	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Physician/surgeon fees	No charge	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$600 copay/visit	$600 copay/visit	Emergency room care: Copayment waived if admitted.
	Emergency medical transportation	$600 copay/transport	$600 copay/transport; deductible does not apply	
	Urgent care	$125 copay/visit	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$2000 copay/day	50% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 50%.
	Physician/surgeon fees	No charge	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $40 copay/visit Outpatient hospital non-surgical services: No charge	Therapy: 50% coinsurance Outpatient hospital non-surgical services: 50% coinsurance	None
	Inpatient services	$2000 copay/day	50% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 50%.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	50% coinsurance	Depending on the type of services, a copayment may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	$2000 copay/day	50% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 50%. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	$100 copay/visit	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Rehabilitation services	Physical, occupational, speech, cognitive, audiology therapy and manipulations: $100 copay/visit	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 50% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50%. Physical, occupational, speech, cognitive, audiology therapy and manipulations: 60 visits per year combined.
	Habilitation services	Physical, occupational, speech, audiology therapy and manipulations: $100 copay/visit	Physical, occupational, speech, audiology therapy and manipulations: 50% coinsurance	
	Skilled nursing care	$100 copay/day	50% coinsurance	60 day limit per year. Preauthorization may be required - if not obtained, penalty will be 50%.
	Durable medical equipment	No charge	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%. Excludes vehicle and home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if it is prescribed by a physician)
- Chiropractic care - spinal manipulations are covered
- Cosmetic surgery (if to correct a functional impairment)
- Dental care (Adult) (if for dental injury of a sound natural tooth)
- Hearing aids (1 aid per ear per 36 months to age 19)
- Private-duty nursing (while hospital confined)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- www.humana.com or 866-4ASSIST (427-7478).
- Texas Department of Insurance: 800-252-3439 or www.tdi.texas.gov.
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- www.humana.com or 866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

- Texas Department of Insurance: 800-252-3439 or www.tdi.texas.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 866-4ASSIST (427-7478) (TTY: 711).

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$100
Hospital (facility) copayment	$2000
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$4,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$100
Hospital (facility) copayment	$2000
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$100
Hospital (facility) copayment	$2000
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Dental

Services	Humana Traditional Plus 14
Carrier Website	www.myhumana.com
Deductible	$50 Individual $150 Family Applies to Basic and Major services only
Diagnostic & Preventive Services	**100%** Oral Examinations, Cleanings & X-Rays, Fluoride Treatments & Sealants (through age 14)
Basic Services	**80%** Fillings, Space Maintainers, Basic Extractions
Major Services	**50%** Bridges, Crowns, Dentures, Endodontics & Periodontics
Orthodontia	Up to 20% discount if in Humana network
Annual Maximum	**Unlimited**

Humana Dental Traditional Plus 14

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	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	Unlimited			
Preventive services				
• Routine oral examinations (2 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (2 per year) • Fluoride treatment (1 per year, through age 14) • Sealants (permanent molars, through age 14) • Space maintainers (primary teeth, through age 14) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		100% no deductible	
Basic services				
• Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14)	50% after deductible		50% after deductible	
Major services				
• Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth ever 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use) • Implant Related Services (crowns, bridges, and dentures each limited to 1 per tooth every five years. Coverage limited to equivalent cost of a non-implant service. Implant placement itself is not covered.) • Periodontics (periodontal cleanings 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)	50% after deductible		50% after deductible	

Orthodontia services

Members may receive a discount on non-covered services of up to 20%. Members may contact their participating provider to determine if any discounts are available on non-covered services.

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the usual and customary charge. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Waiting periods

Enrollment type	Group size	Preventive	Basic	Major [1]	Orthodontia [1]
Initial enrollment, open enrollment, and timely add-on	2-9 enrolled employees	No	No	12 months [2]	24 months [2]
Initial enrollment, open enrollment, and timely add-on	10 or more enrolled employees	No	No	No	12 months [2] (No waiting period for employer-sponsored)
Late applicant [3,4]	2+ enrolled employees	No	12 months	12 months	12 months (24 months for 2-9 enrolled employees)

[1] Preventive Plus does not cover major and orthodontia services.
[2] Waiting periods may be decreased or waived based on the number of months the member had dental insurance immediately before their effective date. Members must have prior orthodontic insurance to reduce or waive the orthodontic waiting period.
[3] Late applicants not allowed with open enrollment option.
[4] Waiting periods do not apply to endodontic services unless a late applicant.

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit **Humana.com**.

Feel good about choosing a Humana Dental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your Humana Dental Traditional Preferred plan focuses on prevention and early diagnosis, providing four exams and cleanings every calendar year: two regular and two periodontal.
* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth:

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* Humana Dental helps you feel good about your dental health so you can smile confidently.
* American Academy of Cosmetic Dentistry

Use your Humana Dental benefits

Find a dentist

With Humana Dental's Traditional Preferred plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in the Humana Dental Traditional Preferred Network. To find a dentist in Humana Dental's Traditional Preferred Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

The other side of this page gives you a summary of Humana Dental benefits. Your plan certificate describes your Humana Dental benefits, including limitations and exclusions. You can find it on MyHumana, your personal page at **Humana.com** or call 1-800-233-4013.

See your dentist

Your Humana Dental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at **Humana.com**.

Learn what your plan paid

After Humana Dental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

Humana®

Plan summary created on: 8/14/23 10:41

Policy Number: TX-70090-HC 1/14

Vision

	Humana - 130	
Services	**Participating Providers**	**Non-Participating Providers**
Exam w/dilation	100% After $10 Copay	$30 Allowance
Lenses • Single • Bifocal • Trifocal • Lenticular	100% After $15 Copay 100% After $15 Copay 100% After $15 Copay 100% After $15 Copay	$20 Allowance $40 Allowance $60 Allowance $100 Allowance
Frames	$130 Allowance	$65 Allowance
Contact Lenses • Elective • Medically Necessary	$130 Allowance 100%	$104 Allowance $200 Allowance
Frequency • Examination • Lenses or Contacts • Frame	Once every 12 months Once every 12 months Once every 24 months	Once every 12 months Once every 12 months Once every 24 months

Humana Vision 130
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Vision care services

	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging [1]	Up to $39	Not covered
Contact lens exam options [2]		
• Standard contact lens fit and follow-up	Up to $40	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames [3]	$130 allowance 20% off balance over $130	$65 allowance
Standard plastic lenses [4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Lens options [4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
– Tier 1	$57	Not covered
– Tier 2	$68	Not covered
– Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
– Tier 1	$110	Not covered
– Tier 2	$120	Not covered
– Tier 3	$135	Not covered
– Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses [5] (applies to materials only)		
• Conventional	$130 allowance, 15% off balance over $130	$104 allowance
• Disposable	$130 allowance	$104 allowance
• Medically necessary	$0	$200 allowance

Vision care services

	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts may be available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or lenses for frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members may receive 20% off the retail price.

- Members may also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Since Lasik or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Questions?

Check out **Humana.com**
Call 1-866-995-9316 seven days a week:
8 a.m. to 6 p.m. Eastern Time
Monday through Saturday and
11 a.m. to 8 p.m. Sunday.

Humana®

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York. In Arizona, group vision plans insured by Humana Insurance Company. In New Mexico, group vision plans insured by Humana Insurance Company.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Added Services

Wellness: **Go 365**

Virtual Visits: **Dr on Demand**

KITCHEN
HOTEL ROOM
OFFICE

YOUR LIVING ROOM IS NOW YOUR DOCTOR'S OFFICE

dr. on demand

Humana.

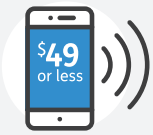
Board-certified doctor ▷▷ **$49 or less** ▷▷ **Download the app**

Four easy steps to get started
Download from the App Store or Google Play.

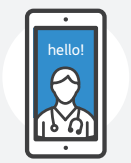
1. Download the app

2. Enter your health insurance information; select Humana and enter your group ID and member ID

3. Enter a payment method



4. See a doctor within minutes



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The doctor will see you now

Skip the waiting. Doctor On Demand allows you see to see a board-certified doctor in minutes, with video access from your mobile device or computer. It's easy.

Doctor On Demand is the perfect option when your primary care doctor is unavailable and other healthcare options are closed. You may receive treatment 24 hours a day, seven days a week for many health issues including:

- Colds, flu and sore throat
- Upper respiratory infections
- Skin and eye problems
- Urinary tract infections

Telemedicine is not for emergencies such as chest pain, abdominal pain or shortness of breath.

Doctor On Demand may treat members except children under the age of two for non-emergency health conditions. If needed, your physician may send a prescription to your pharmacy.

Video visits cost **$49 OR LESS**
based on your medical plan.

Telemedicine is not a substitute for emergency care and not intended to replace your primary care doctor or other providers in your network.

Behavioral health visits are not covered. Limitations on health care and prescription services delivered by telemedicine and communication options vary by state. This material is provided for informational use only and should not be considered medical advice or used in place of consulting a licensed medical professional.

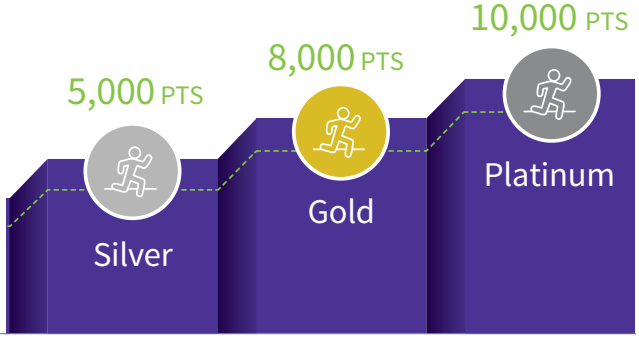
HOW TO REACH YOUR HIGHEST STATUS

Unlock activities to earn more Points and move up! Primary member

Here are the ways you can earn Points in Go365®

1. **Activities:** Things you can do every day to get healthier.
2. **Recommended activities:** Personalized based on your Health Assessment responses.
3. **Challenges:** Motivate yourself and your friends in a healthy competition.

While you can choose any qualified activity, here are popular activities you may complete to reach a new Status.



Activities to reach Silver Status	Points earned Primary member	
Education		
Health Assessment	500	once/program year
First Step Health Assessment Bonus*	500	once/lifetime
Fast Start Health Assessment Bonus	250	once/program year
Calculators x 4	300	75 Points each x 4 up to 300 per program year
Monthly Go365 sign-in x 12	120	10 Points each x 12 up to 120 per program year
First time Go365 App sign-in*	50	once/lifetime
Prevention		
Biometric screening completion	2,000	once/program year
Dental exam x 2	400	200 Points each x 2 up to 400 per program year
Flu shot	200	once/program year
Healthy Living		
Biometric screening in-range results: blood pressure	400	once/program year
Biometric screening in-range results: blood glucose	400	once/program year
Silver Status reached (5,000 Points)	**5,120**	

Bonus Bucks earned at Silver Status

500 Primary member

Double Bonus Bucks earned at Silver Status when prior year highest Status was Silver or when reaching Silver Status for the first time.

1,000 Primary member

*If you already completed a lifetime activity in a prior year, check your recommended activities for things like courses, conversations and overarching lifestyle activities to make up the difference.

Recommended activities are not medical advice. Consult your physician.

Bonus Bucks are not tied to Points and increase a Go365 members' buying power in the Go365 Mall. Bonus Bucks are awarded when a Go365 member reaches Silver, Gold and Platinum Status, and are doubled when the prior year highest Status is achieved. Bonus Bucks apply to the 30,000 Bucks maximum each adult member can earn in a program year.

Go365 is not an insurance product. Not available with all Humana health plans. We are committed to helping you achieve your best health. Rewards for participating in Go365 are available to all members. If you think you might be unable to meet a standard for a Go365 reward, you might qualify for an opportunity to earn the same reward by different means. Contact Go365's Customer Care team by signing in to Go365.com and using the secure live chat feature on the bottom right of the screen or by calling the number on the back of your member ID card, and we will work with you (and, if you wish, with your healthcare practitioner) to develop another way to qualify for the reward.

Activities to reach Gold Status

	Points earned Primary member	
Education		
Update/confirm contact information	50	once/program year
Healthy Living		
Sleep diary x 6 weeks	150	25 Points weekly up to 150 per program year
Fitness habit x 2	50	up to 25 Points per month
Fitness		
First lifetime verified workout*	500	once/lifetime
Complete two 5K walks (Level 1 athletic event)	500	250 Points each up to 3,000/program year
Complete a 10K run (Level 2 athletic event)	350	350 Points each up to 3,000/program year
Daily workout Points (over 12 weeks/3 months)		
Three fitness facility workouts per week	360	10 Points per visit x 36 days
10,000 steps achieved 1 day per week	120	10 Points x 12 days
8,000 steps achieved 3 days per week	288	8 Points x 36 days
Bonus Points—exceeded 50 weekly workout Points	600	50 Points x 12 weeks
Gold Status reached (8,000 Points)	**8,088**	

Bonus Bucks earned at Gold Status

1,500 Primary member

Double Bonus Bucks earned at Gold Status
when prior year highest Status was Gold.

3,000 Primary member

Activities to reach Platinum Status

Prevention		
Vision exam	200	once/program year
Healthy Living		
Virtual well-being coaching ongoing interactions x 20 weeks	200	10 Points per week up to 520 per program year x 20 weeks
Weekly log x 12 weeks	120	10 Points per week x 12 weeks
Daily health quiz x 25 days	50	2 Points per day x 25 days
Blood donation	50	50 Points each up to 300 per program year
Fitness		
Complete a 10K run (Level 2 athletic event)	350	up to 3,000/program year
Daily workout Points (over 24 weeks/6 months)		
Two fitness facility workouts per week	480	10 Points per visit x 48 workouts
7,000 steps achieved 1 day per week	168	7 Points x 24 days
Challenges		
Participate in a Sponsored Challenge x 6	300	50 Points per month total for all Challenge-related activities x 6
Platinum Status reached (10,000 Points)	**10,006**	

Bonus Bucks earned at Platinum Status

5,000 Primary member

Double Bonus Bucks earned at Platinum Status
when prior year highest Status was Platinum.

10,000 Primary member

*If you already completed a lifetime activity in a prior year, check your recommended activities for things like courses, conversations and overarching lifestyle activities to make up the difference.

Women's Health & Cancer Rights Act of 1998:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHRCA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician, for:

1) All stages of reconstruction of the breast on which the mastectomy was performed;

2) Surgery and reconstruction of the other breast to produce a symmetrical appearance:

3) Prostheses; and

4) Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to the other medical and surgical benefits provided under this plan. For more information, contact Human Resources.

Newborn's and Mother's Health Protection Act (Newborn Act):

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

You may be eligible for assistance paying your employer health plan premiums. You should contact your state for further information on eligibility.

TEXAS

www.gethipptexas.com

800-440-0493

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid

www.cms.gov

877-267-2323 Ext. 61565

Who is Eligible for CHIP/ Children's Medicaid?

Texas families with uninsured children may be eligible for health insurance through Children's Medicaid and the Children's Health Insurance Program (CHIP). Both programs offer healthcare benefits, including regular check-ups and dental care. You can apply online at www.chipmedicaid.org, or by phone 800-647-6558. If you qualify for CHIP, you may be subject to a yearly enrollment fee of $0, $35 or $50 based on your monthly income.

CHIP and Children's Medicaid both offer a lot of benefits:

- choice of doctors, regular checkups and office visits
- dentist visits, cleanings and fillings
- prescription drugs and vaccines
- access to medical specialists and mental health care
- hospital care and services
- medical supplies, x-rays and lab tests
- treatment of special health needs
- treatment of pre-existing conditions

A child must be 18 or younger, a Texas resident and a U.S. citizen or legal permanent resident.

Any adult who lives more than half the time with an uninsured child may apply. This includes: parents, step-parents, grandparents, other relatives, legal guardians or adult brothers or sisters.

Important Information

Important Notice from your employer about Your Prescription Drug and Medicare: CREDITABLE COVERAGE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost. with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered by Humana is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current employer coverage will not coordinate with Part D coverage; for those individuals. who elect Part D coverage, coverage under your employer's plan will end for the individual and all covered dependents. If you do decide to join a Medicare drug plan and drop your current employer coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage. your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage please contact Human Resources.

For more information about Medicare prescription drug coverage:

• Visit www.medicare.gov.

• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

• Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Form Approved OMB No. 1210-0149 (expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

For more information about available coverage offered by your employer, please check your summary plan description or contact your Humana Resources Department.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.