

# Humana National POS

Form CCP Figure 1

## TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE FOR ALL GROUP CONSUMER CHOICE POINT OF SERVICE (POS) BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Standard Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
Outpatient Physician Services	Subject To Deductible	
Advanced Diagnostic Imaging (PET, CAT, MRI, MRA, SPECT)	Subject To Deductible	
Therapeutic Radiology Services	Subject To Deductible	
Home Health Services	Subject To Deductible	
Preventive Endoscopic Services (including Colonoscopy)	Subject To Deductible	
Inpatient Hospital Services	Subject To Deductible	
Inpatient Physician Care Services	Subject To Deductible	
Outpatient Hospital Services	Subject To Deductible	
Breast Reconstruction	Subject To Deductible	
Osteoporosis	Subject To Deductible	
Outpatient Visit Limits for Basic Mental Health, Chemical and Alcohol Dependency	20 Visit Limit Combined	
Inpatient Day Limits for Basic Mental Health, Chemical and Alcohol Dependency	Subject To Deductible & 15 Day Limit Combined	
Outpatient Rehabilitation Therapies: Physical, Speech, Cognitive, Audiology & Occupational	Subject To Deductible & 25 Visit Limit Combined	
Serious Mental Illness (including offer rider for groups with 2-50 employees)	Subject To Deductible	
Inability to undergo Dental Treatment	Subject To Deductible	
Hearing Aids		Excluded
TMJ		Excluded
In-vitro Fertilization Services		Excluded

This POS Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other POS plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at [www.tdi.state.tx.us/consumer/indexc.html](http://www.tdi.state.tx.us/consumer/indexc.html), or by calling 1-800-252-3439.

Signature of Applicant

Name of Applicant

Name of Business (if applicable)

Address

City

State

Zip

Date

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. You have the right to a copy of this written disclosure statement free of charge. A new form must be completed upon each subsequent renewal of this policy.