



life care

**LOW DEDUCTIBLE PACKAGE**  
PREFERRED PROVIDER BENEFIT PLAN

**ARIZONA Plan 38, Option 018**

		Plan pays for services at <b>PARTICIPATING</b> providers		Plan pays for services at <b>NONPARTICIPATING</b> providers	
<b>Annual Deductible (1)</b>	<ul style="list-style-type: none"> <li>Annual amount (<i>does not apply to maximum out-of-pocket expense</i>)</li> <li>Deductible carryover</li> </ul>	<b>Single Deductible</b> \$1,000	<b>Family Deductible (2)</b> \$2,000	<b>Single Deductible</b> \$2,000	<b>Family Deductible (2)</b> \$4,000
		Covered expenses incurred in the last three months of the calendar year and applied to the deductible will also be credited to the next calendar year deductible.			
<b>Maximum Out-of-Pocket Expense Limit (1)</b>	<ul style="list-style-type: none"> <li>Individual (<i>must be satisfied by each covered person</i>)</li> </ul>	<b>Single</b> \$2,000	<b>Family</b> \$4,000	<b>Single</b> \$8,000	<b>Family</b> \$10,000
<b>Lifetime Maximum Benefit</b>		\$5,000,000 per covered person			
<b>Preventive Care</b>	<ul style="list-style-type: none"> <li>Routine annual physical exam (3), (4)</li> <li>Routine Pap smears and PSA (3), (4), (5)</li> <li>Routine lab, pathology and X-ray (3), (4)</li> <li>Routine immunizations (<i>to age 18</i>)</li> <li>Routine mammograms (5)</li> </ul>	<b>80%</b>		Not Covered	
		<b>100%</b>		Not Covered	
		<b>80%</b>		<b>60%</b> after deductible	
<b>Physician Services</b>	<ul style="list-style-type: none"> <li>Office visits (<i>primary care</i>) (1), (12)</li> <li>Office visits (<i>specialty</i>) (1), (12)</li> <li>Diagnostic lab and X-ray (10), (12)</li> <li>Allergy testing, injections and serum</li> <li>Inpatient services</li> <li>Outpatient services (<i>includes surgery</i>) (6)</li> </ul>	\$25 copayment		<b>60%</b> after deductible	
		\$40 copayment		<b>60%</b> after deductible	
		First \$200 paid at <b>100%</b> then <b>80%</b> after deductible		<b>60%</b> after deductible	
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<b>Hospital Services</b>	<ul style="list-style-type: none"> <li>Inpatient care</li> <li>Outpatient surgery – facility (6)</li> <li>Outpatient nonsurgical</li> <li>Emergency room (<i>including physician visits</i>)</li> </ul>	<b>80%</b> after deductible		<b>60%</b> after deductible	
<b>Other Medical Services</b>	<ul style="list-style-type: none"> <li>Skilled nursing facility (<i>up to 30 days per calendar year</i>) (7)</li> <li>Home health care (7)</li> <li>Complications of pregnancy and sick baby services</li> <li>Durable medical equipment (<i>up to \$2,500 maximum per calendar year</i>) (7)</li> <li>Hospice (7), (8)</li> <li>Transplant services (<i>organ</i>) (7)</li> </ul>	<b>80%</b> after deductible		<b>60%</b> after deductible	
		<b>50%</b> after deductible		<b>50%</b> after deductible	
		<b>80%</b> after deductible ( <i>when services are performed at a National Transplant Network provider</i> )		<b>60%</b> after deductible ( <i>subject to separate out-of-pocket maximum of \$35,000 per calendar year</i> )	
<b>Mental Health</b> ( <i>includes mental disorders, alcohol and chemical dependence</i> ) (3)	<ul style="list-style-type: none"> <li>Inpatient and Outpatient care (<i>Combined \$2,500 per calendar year maximum. Outpatient care not to exceed \$500 of the \$2,500 calendar year maximum.</i>)</li> </ul>	<b>50%</b> after deductible		<b>50%</b> after deductible	



ARIZONA Plan 38, Option 018	Plan pays for services at <b>PARTICIPATING</b> providers	Plan pays for services at <b>NONPARTICIPATING</b> providers										
<b>Optional Benefits</b> (9)	<ul style="list-style-type: none"> <li>• Maternity including routine newborn care and post-hospital follow-up (<i>waiting period applies</i>) (1), (3)</li> </ul>	<ul style="list-style-type: none"> <li>• 60% after \$500 maternity deductible</li> <li>• 40% after \$1,000 maternity deductible</li> </ul>										
<b>Prescription Drugs</b> (11)	<ul style="list-style-type: none"> <li>• <b>Coverage at participating pharmacies</b> When you present your ID card at a pharmacy, you are required to pay the balance, if any, to the pharmacy for each prescription based on the current assigned level of the drug. There are no claim forms to file if you use a participating pharmacy and present your ID card with each prescription.</li> </ul> <table border="0" data-bbox="370 709 1089 835"> <thead> <tr> <th data-bbox="370 709 732 737"><b>Drugs assigned to:</b></th> <th data-bbox="732 709 1089 737"><b>Allowance per prescription or refill</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="370 737 732 764">Group A:</td> <td data-bbox="732 737 1089 764"><b>\$30*</b></td> </tr> <tr> <td data-bbox="370 764 732 791">Group B:</td> <td data-bbox="732 764 1089 791"><b>\$20*</b></td> </tr> <tr> <td data-bbox="370 791 732 819">Group C:</td> <td data-bbox="732 791 1089 819"><b>\$10*</b></td> </tr> <tr> <td data-bbox="370 819 732 846">Group D:</td> <td data-bbox="732 819 1089 846"><b>\$0**</b></td> </tr> </tbody> </table> <p data-bbox="370 846 1247 890">* For Drug Groups A, B and C, your share of the cost will never exceed \$100 for each prescription or refill. And, your total out-of-pocket expenses will never exceed \$2,500 per member during your plan year.</p> <p data-bbox="370 890 1268 917">** For Drug Group D, there is no limit on your share of the cost for each prescription or for the calendar year.</p> <p data-bbox="370 917 1451 961">The amount you pay for covered prescription drugs is determined on a per prescription or refill basis, and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.</p> <ul style="list-style-type: none"> <li>• <b>Mail-order benefit</b> For your convenience, you may receive a maximum 90-day supply per prescription or refill through the mail (maximum 30-day supply for self-administered injectable drugs). The same requirements apply when purchasing medications through a participating mail-order pharmacy as apply when purchasing in person at a pharmacy. Members can call <b>Customer Service</b> at (866) 852-6923 or log in to <a href="http://www.virginlifecare.com">www.virginlifecare.com</a> and visit their medical insurance self-service page for more information, including mail-order forms.</li> </ul>		<b>Drugs assigned to:</b>	<b>Allowance per prescription or refill</b>	Group A:	<b>\$30*</b>	Group B:	<b>\$20*</b>	Group C:	<b>\$10*</b>	Group D:	<b>\$0**</b>
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**This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.**



**MEDIUM DEDUCTIBLE PACKAGE**  
PREFERRED PROVIDER BENEFIT PLAN

**ARIZONA Plan 38, Option 018**

Plan pays for services at **PARTICIPATING** providers

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		<b>Single Deductible</b>	<b>Family Deductible (2)</b>	<b>Single Deductible</b>	<b>Family Deductible (2)</b>
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## life care

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

- (1) Copayments do not apply to the deductible or out-of-pocket maximum. The medical out-of-pocket maximum does not apply to transplant services from National Transplant Network providers, prescription drugs, mental health services or maternity, if the optional maternity benefit is selected.
- (2) Two or three family members must meet their individual deductible, depending on the deductible amount selected.
- (3) Benefit payable after 90-day waiting period for preventive care, 12 month waiting period for mental health and 270-day waiting period for maternity.
- (4) \$300 of covered expenses per person per calendar year, subject to applicable coinsurance.
- (5) Age and/or frequency limits apply.
- (6) Outpatient benefits payable after 90-day waiting period for nonemergency removal of tonsils and/or adenoids, and 180-day waiting period for nonemergency surgical treatment for bunions, varicose veins, hemorrhoids or hernia (does not include strangulated or incarcerated hernia).
- (7) Prior authorization required in order to be eligible for these benefits.
- (8) Counseling for the hospice patient and immediate family is limited to 15 visits per family per lifetime, Medical Social Services limited to \$100 per family per lifetime.
- (9) These benefits are optional and can be added to your plan for an additional cost. Optional benefits may not be available in all areas.
- (10) This benefit does not cover MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies. Primary care physicians include family practitioner, general practitioner, gynecologist, pediatrician or internist; specialist includes any other participating physician. Please contact Customer Service for details.
- (11) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claims with Humana for reimbursement. When a nonparticipating pharmacy is used, members are charged an additional 30 percent of the actual charge made by the dispensing pharmacy.
- (12) Does not apply to preventive routine care.

*For information on plans available to HIPAA eligible individuals, please call (800) 833-6916.*

**Payments** - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your policy.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable

fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

**Participating primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or**

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



## **PPO RxIMPACT PRESCRIPTION DRUG COVERAGE**

GROUP A - \$30, GROUP B - \$20, GROUP C - \$10, GROUP D - \$0

### **How the RxImpact structure works**

With RxImpact, drugs are organized by their ability to prevent a serious medical episode and by the timeframe in which they impact medical expenses.

The RxImpact plan pays a specific allowance benefit (dollar amount) to a pharmacy for each prescription or refill. The allowance amount is usually different for each group of drugs. You pay the balance, if any, of the amount due to the pharmacy.

The groups are organized as follows:

- **Group A:** Drugs with the greatest ability to prevent a serious medical episode. Includes brand and generic drugs for conditions such as asthma, infections, depression, juvenile diabetes, as well as pregnancy prevention. Antibiotics, insulin, and contraceptives are examples of drugs in this group.
- **Group B:** Drugs for the control of chronic (long-term) conditions. Includes brand and generic drugs that treat cancer, heart disease, AIDS, and multiple sclerosis. Heart medications, cholesterol-lowering medications, estrogen, and oral diabetic drugs are in this group.
- **Group C:** Drug that may reduce symptoms and improve day-to-day functioning. Includes brand and generic drugs that treat allergies, arthritis, and indigestion. Antihistamines, anti-inflammatories, antacids, and pain medications are in this group.
- **Group D:** Drugs that may improve psychological, emotional or physical well-being. Includes brand and generic drugs for obesity, sexual dysfunction, and acne. Many drugs in this group are not covered by other prescription drug plans.

Prescription drug products, or classes of certain prescription drug products, are generally reviewed on an ongoing basis by a Humana Pharmacy and Therapeutics committee, which is composed of physicians and pharmacists. Drugs are reviewed for safety, clinical effectiveness and cost-effectiveness prior to assignment or a change in assignment to one of the groups. Coverage of a prescription drug or placement of the drug within a group are subject to change throughout the year. In the event drugs are moved to categories with higher member cost, advance notice is provided based on past usage. Always discuss prescription drugs with your physician to determine appropriateness or clinical effectiveness with respect to you or any specific illness.

Members can log in to [www.virginlifecare.com](http://www.virginlifecare.com) and visit their medical insurance self-service page for information about their prescription drug(s) and corresponding benefits and for a current RxImpact Drug List, or they can call Customer Service with questions at (866) 852-6923.

For a complete listing of participating pharmacies, please refer to [www.virginlifecare.com](http://www.virginlifecare.com) or call customer service at (866) 852-6923.



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

**PRE-EXISTING CONDITIONS**

A pre-existing condition is a sickness or injury, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, during the six month period before the covered person's effective date of coverage. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with us. We will waive the pre-existing conditions limitation for those conditions disclosed on the application provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

**OTHER EXPENSES NOT COVERED**

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

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