



life care

**HIGH DEDUCTIBLE HEALTH PLAN 100/70**

PREFERRED PROVIDER BENEFIT PLAN

**FLORIDA Plan 38, Option 200**

Plan pays for services from  
**PARTICIPATING** providers

Plan pays for services from  
**NONPARTICIPATING** providers

		<b>Single Deductible</b>	<b>Family Deductible (2)</b>	<b>Single Deductible</b>	<b>Family Deductible (2)</b>
<b>Annual Deductible (1)</b>	<ul style="list-style-type: none"> <li>Annual amount</li> </ul>	\$3,000 \$5,000	\$6,000 \$10,000	\$6,000 \$10,000	\$12,000 \$20,000
<b>Maximum Out-of-Pocket Expense Limit (1), (2)</b>	<ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$0	\$0	\$6,000	\$12,000
<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 immunizations (age 17 to age 18) (3), (4)</li> <li>Routine Pap smears and PSA (3), (4), (5)</li> <li>Routine Mammograms (5)</li> <li>Routine lab, pathology and X-ray (3), (4)</li> <li>Child health supervision services (includes immunizations; birth to age 17; maximum of 18 visits per covered child)</li> </ul>	<b>100%</b>		<b>50%</b> after deductible	
<b>Physician Services</b>	<ul style="list-style-type: none"> <li>Office visits (includes diagnostic lab and X-ray)</li> <li>Allergy testing, injections and serum</li> <li>Inpatient services</li> <li>Outpatient services (includes surgery) (6)</li> </ul>	<b>100%</b> after deductible		<b>70%</b> after deductible	
<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 (including physician visits)</li> </ul>	<b>100%</b> after deductible		<b>70%</b> after deductible	
<b>Prescription Drugs (7)</b>	<ul style="list-style-type: none"> <li>Benefit for each prescription or refill (up to 30-day supply)</li> <li>Mail order (90-day supply)</li> </ul>	<b>100%</b> after deductible		<b>70%</b> after deductible	
<b>Other Medical Services</b>	<ul style="list-style-type: none"> <li>Skilled nursing facility (up to 30 days per calendar year) (8)</li> <li>Home health care (up to 60 visits per calendar year) (8)</li> <li>Durable medical equipment (up to \$2,500 maximum per calendar year.) (8)</li> <li>Hospice (8), (9)</li> <li>Complications of pregnancy and sick baby services</li> <li>Transplant services (organ) (8)</li> </ul>	<b>100%</b> after deductible	<b>50%</b> after deductible	<b>70%</b> after deductible	<b>70%</b> after deductible
<b>Mental Health</b> <i>(includes mental disorders, alcohol and chemical dependence, waiting period applies) (3)</i>	<ul style="list-style-type: none"> <li>Inpatient and Outpatient care (Combined \$2,500 per calendar year maximum. Outpatient care not to exceed \$500 of the \$2,500 calendar year maximum.)</li> </ul>	<b>50%</b> after deductible		<b>50%</b> after deductible	



life care

**HIGH DEDUCTIBLE HEALTH PLAN 80/60**

PREFERRED PROVIDER BENEFIT PLAN

**FLORIDA Plan 38, Option 201**

Plan pays for services from **PARTICIPATING** providers

Plan pays for services from **NONPARTICIPATING** providers

		<b>Single Deductible</b>	<b>Family Deductible (2)</b>	<b>Single Deductible</b>	<b>Family Deductible (2)</b>
<b>Annual Deductible (1)</b>	<ul style="list-style-type: none"> <li>Annual amount</li> </ul>	\$2,000 \$3,000	\$4,000 \$6,000	\$4,000 \$6,000	\$8,000 \$12,000
<b>Maximum Out-of-Pocket Expense Limit (1), (2)</b>	<ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$2,000	\$4,000	\$8,000	\$16,000
<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 immunizations (age 17 to age 18) (3), (4)</li> <li>Routine Pap smears and PSA (3), (4), (5)</li> <li>Routine Mammograms (5)</li> <li>Routine lab, pathology and X-ray (3), (4)</li> <li>Child health supervision services (includes immunizations; birth to age 17; maximum of 18 visits per covered child)</li> </ul>	<b>80%</b>		<b>50%</b> after deductible	
		<b>100%</b>		<b>100%</b>	
		<b>80%</b> after deductible		<b>50%</b> after deductible	
		<b>80%</b>		<b>60%</b>	
<b>Physician Services</b>	<ul style="list-style-type: none"> <li>Office visits (includes diagnostic lab and X-ray)</li> <li>Allergy testing, injections and serum</li> <li>Inpatient services</li> <li>Outpatient services (includes surgery) (6)</li> </ul>	<b>80%</b> after deductible		<b>60%</b> after deductible	
<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 (including physician visits)</li> </ul>	<b>80%</b> after deductible		<b>60%</b> after deductible	
<b>Prescription Drugs (7)</b>	<ul style="list-style-type: none"> <li>Benefit for each prescription or refill (up to 30-day supply)</li> <li>Mail order (90-day supply)</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 (up to 30 days per calendar year) (8)</li> <li>Home health care (up to 60 visits per calendar year) (8)</li> <li>Durable medical equipment (up to \$2,500 per calendar year.) (8)</li> <li>Hospice (8), (9)</li> <li>Complications of pregnancy and sick baby services</li> <li>Transplant services (organ) (8)</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		<b>60%</b> after deductible	
		<b>80%</b> after deductible (when services are performed at a National Transplant Network provider)		<b>60%</b> after deductible (subject to separate out-of-pocket maximum of \$35,000 per calendar year)	
<b>Mental Health (includes mental disorders, alcohol and chemical dependence, waiting period applies) (3)</b>	<ul style="list-style-type: none"> <li>Inpatient and Outpatient care (Combined \$2,500 per calendar year maximum. Outpatient care not to exceed \$500 of the \$2,500 calendar year maximum.)</li> </ul>	<b>50%</b> after deductible		<b>50%</b> after deductible	



## 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) Must meet deductible in addition to the out-of-pocket maximum. The medical out-of-pocket maximum does not apply to transplant services or mental health services from National Transplant Network providers.
- (2) For other than single coverage, the family deductible applies. The single deductible applies to single coverage policies only.

- (3) Benefit payable after 90-day waiting period for preventive care and 12-month waiting period for mental health.
- (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) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- (8) Prior authorization required in order to be eligible for these benefits.
- (9) Counseling for hospice patient and immediate family is limited to 15 visits per family per lifetime, Medical Social Services limited to \$100 per family per lifetime.

*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 Certificate of Insurance.

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.

**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.**

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

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

**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.**

HealthMiles Plus is brought to you by Virgin Life Care and Humana and is insured by Humana Health Insurance Company of Florida, Inc.



**This is an outline of the limitations and exclusions for the Humana 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 which was diagnosed or treated, or which produced signs or symptoms that would cause an ordinary prudent person to seek medical advice, care or treatment, during the 24-month period before the covered person's effective date of coverage. Routine follow-up care to determine the reoccurrence of breast cancer does not constitute medical advice, care or treatment. 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.
2. Services not authorized or prescribed 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.
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.
17. Infertility services.
18. Pregnancy and well-baby expenses.
19. Elective medical or surgical procedures; sterilization, 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 rendered 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. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat sickness or bodily injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures.
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.
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 unless diagnostic and/or surgical procedures are medically necessary to treat conditions caused by congenital or developmental deformity, disease or injury.
33. Services or supplies received in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, for which benefits are paid under Workers' Compensation. This exclusion does not apply to services or supplies received by a covered person qualifying as a sole proprietor, officer or partner under the laws of that state, and such benefits are not paid under any Workers' Compensation plan, provided he or she will not receive benefits under a Workers' Compensation plan.
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, except as stated in the policy.
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.