



life care

**LOW DEDUCTIBLE PACKAGE**  
PREFERRED PROVIDER BENEFIT PLAN

**FLORIDA Plan 38, Option 001**

Plan pays for services at **PARTICIPATING** providers

Plan pays for services at **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 (<i>does not apply to maximum out-of-pocket expense</i>)</li> <li>Deductible carryover</li> </ul>	\$1,000	\$2,000	\$2,000	\$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>	Individual ( <i>must be satisfied by each covered person</i> )	<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 immunizations (<i>ages 17 to 18</i>) (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 (<i>includes immunizations; birth to age 17; maximum of 18 visits per covered child</i>)</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 (<i>includes diagnostic lab and X-ray</i>)</li> <li>Allergy testing, injections and serum</li> <li>Inpatient services</li> <li>Outpatient services (<i>includes surgery</i>) (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 (<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 (<i>up to 60 visits per calendar year</i>) (7)</li> <li>Durable medical equipment (<i>up to \$2,500 maximum per calendar year</i>) (7)</li> <li>Hospice (7) (8)</li> <li>Complications of pregnancy and sick baby services</li> <li>Transplant services (<i>organ</i>) (7)</li> </ul>	<b>80%</b> after deductible		<b>60%</b> after deductible	
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		<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; waiting period applies</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	



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<p><b>Optional Benefits (9)</b></p>	<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> <li>• Office visit copayment option (<i>includes diagnostic tests, lab and X-rays, paid at 100% up to \$100 per calendar year. Does not apply to preventive/routine care</i>) (1), (10)</li> </ul>	<p><b>60%</b> after \$500 maternity deductible</p> <p><b>100%</b> after \$25 copayment for primary care physician and \$40 copayment for specialist limited to four combined visits (<i>primary care physician and specialist</i>) per calendar year. After four visits, plan pays <b>80%</b> after deductible</p>	<p><b>40%</b> after \$1,000 maternity deductible</p> <p><b>60%</b> after deductible</p>										
<p><b>Prescription Drugs (11)</b></p>	<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"> <thead> <tr> <th data-bbox="394 905 588 931"><b>Drugs assigned to:</b></th> <th data-bbox="764 905 1117 931"><b>Allowance per prescription or refill</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="394 931 478 952">Group A:</td> <td data-bbox="764 931 814 952"><b>\$30*</b></td> </tr> <tr> <td data-bbox="394 952 478 974">Group B:</td> <td data-bbox="764 952 814 974"><b>\$20*</b></td> </tr> <tr> <td data-bbox="394 974 478 996">Group C:</td> <td data-bbox="764 974 814 996"><b>\$10*</b></td> </tr> <tr> <td data-bbox="394 996 478 1024">Group D:</td> <td data-bbox="764 996 814 1024"><b>\$0**</b></td> </tr> </tbody> </table> <p>* 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>** For Drug Group D, there is no limit on your share of the cost for each prescription or for the calendar year.</p> <p>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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## 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 and 12 month waiting period for mental health and 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.

*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.

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.

**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

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



**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 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. 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.
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.
39. No coverage for drugs filled at a nonparticipating pharmacy.