Humana One®

SUMMARY OF BENEFITS FOR NEVADA

Individual Health Insurance

Standard Plan

NV-46161-HH 9/06

Humana*One* NEVADA

Plan 49, Option 022

	Plan pays for services at ***PARTICIPATING*** providers		Plan pays for services at ***NONPARTICIPATING*** providers	
Annual Deductible (1)	**Single Deductible**	**Family Deductible** (2)	**Single Deductible**	**Family Deductible** (2)
• Annual amount *(does not apply to maximum out-of-pocket expense)*	$ 500	$ 1,500	$ 1,000	$ 3,000
Maximum Out-of-Pocket Expense Limit (1)				
• Individual *(must be satisfied by each covered person)*	$2,000		$4,000	
• Family	$3,500		$7,000	
Lifetime Maximum Benefit	$1,000,000 per covered person			
Preventive Care (3)				
• Routine annual physical exam	$10 copay, then **100%**		**60%**	
• Routine immunizations *(to age 18)* (4) • Routine Pap smears • Routine Mammograms (4) • Routine PSA (4) • Routine lab, pathology and X-ray	**80%**		**60%**	
Physician Services				
• Office visits *(includes diagnostic lab and X-ray)*	$10 copay, then **100%**		**60%** after deductible	
• Inpatient services • Outpatient services *(includes surgery)*	**80%** after deductible		**60%** after deductible	
Hospital Services				
• Inpatient care • Outpatient surgery – facility • Outpatient nonsurgical • Emergency room *(including physician visits)*	**80%** after deductible		**60%** after deductible	
Prescription Drugs (5)				
• Benefit for each prescription or refill *(up to 30-day supply)*	**80%** after deductible		**60%** after deductible	
Other Medical Services				
• Home health care *(up to 100 visits per calendar year)* (6) • Durable medical equipment (6) • Hospice (6) • Complications of pregnancy and sick baby services • Transplant services *(organ)* (6) *(up to $100,000 per person per lifetime for all covered transplants)*	**80%** after deductible		**60%** after deductible	
Severe Mental Illness				
• Inpatient *(up to 40 days per calendar year)* • Outpatient therapy *(up to 40 visits per calendar year)*	**80%** after deductible		**60%** after deductible	

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.

	Plan pays for services at ***PARTICIPATING*** providers	Plan pays for services at ***NONPARTICIPATING*** providers
Mental Illness Other than Severe Mental Illness • Inpatient *(up to 30 days per calendar year)* • Outpatient therapy *(up to 20 visits per calendar year)*	**80%** after deductible	**60%** after deductible
Substance Abuse *(Chemical, Alcohol dependence and Detoxification)* • Inpatient *(up to $9,000 maximum per calendar year)* • Outpatient therapy *(up to $2,500 maximum per calendar year)* • Treatment for Withdrawal *(up to $1,500 maximum per calendar year)*	**80%** after deductible	**60%** after deductible

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.
(2) The family deductible can be met by multiple family members without a single family member meeting his/her single deductible.
(3) Combined benefit maximum for all preventive care is $250 per person per calendar year.
(4) Age and/or frequency limits apply.
(5) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
(6) Prior authorization required in order to be eligible for these benefits.

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 judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

Medical Limitations and Exclusions

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

PRE-EXISITING CONDITIONS

A pre-existing condition is a sickness or injury 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 (whether or not prescribed by a health care practitioner) or which are experimental, investigational or for research purposes.
2. Expenses incurred before the effective date or after the date coverage terminated.
3. Services required by law to be treated in a public facility for which a charge is normally not made; provided by a person who is a family member; performed by a health care practitioner on himself/herself; performed in association with a service that is not covered under the policy; provided at no cost or for which there is no legal obligation to pay.
4. Complications related to a non-covered service.
5. Cosmetic procedures except for reconstructive surgery following a mastectomy.
6. Fertility or Infertility services.
7. Vitamins, dietary products and nonprescription formulas or supplements (except for treatment of inherited metabolic diseases); over the counter drugs; drugs approved by the FDA for experimental or investigational use.
8. Sexual dysfunction; reversal of sterilization or subsequent resterilization; elective abortion.
9. Genetic testing, counseling, treatment or therapy; marital/family counseling; occupational, religious or other social maladjustments; behavior disorders, codependency; impulse control disorders; organic disorders; learning disabilities or mental retardation.
10. Services for weight reduction regardless of any associated medical or psychological conditions unless medically necessary; weight loss programs (whether or not prescribed by a health care practitioner)
11. Eye exams (except to diagnosis injury or sickness); eye glasses or contact lenses; radial keratotomy or surgical procedures for refractive correction.
12. Hearing exams (except to diagnosis injury or sickness); physical exams for employment, licensing, insurance, school, camp, sports or adoption; immunizations for foreign travel; court ordered exams or treatment or in connection with legal proceedings unless medically necessary.
13. Dental services (except for dental injury); appliances or supplies.
14. War, insurrection, rebellion or armed invasion or aggression; participation in a riot or while committing a felony.
15. Personal comfort, hygiene or convenience items unless medically necessary; modifications to a residence or equipment to accommodate physical handicaps or disabilities; nonmedical equipment; wigs; arch supports, support stockings, special show accessories or corrective shoes unless an integral part of a lower-body brace.
16. Sports medicine services to improve athletic ability; services rendered by a pain control center or under a pain control program; acupuncture; hypnosis.
17. Private room charges in excess of the average semi-private room rate; charges for late discharge or resulting from a cancelled appointment or procedure; travel and lodging accommodations (whether or not prescribed by a health care practitioner).
18. Inpatient services when the stay is due to environment control, custodial care, domiciliary care, rest cures or convalescent care (except skilled nursing care).
19. Injury or sickness arising out of or in the course of any employment for pay or profit.
20. Ecological or environmental medicine; use of chelation or orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not approved by the FDA as effective for treatment; electrodiagnosis, hahnemannian dilution and succession; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile gerovital.
21. Milieu therapy; biofeedback; behavior modification, sensitivity training; hydrotherapy; electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolfing, residential treatment, vocational rehabilitation and wilderness programs.

Notes

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Insured by Humana Insurance Company

Policy Number:
NV-70130 STD 8/2002, et al
NV-70130 BSC 8/2002, et al

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