

SUMMARY OF BENEFITS FOR UTAH

Individual Health Insurance

Basic Plan



Humana **One** UTAH

Plan 49, Option 019

Plan pays for services at
PARTICIPATING providers

Plan pays for services at
NONPARTICIPATING providers

	Single Deductible	Family Deductible (3)	Single Deductible	Family Deductible (3)
Annual Deductible (1), (2) <ul style="list-style-type: none"> Annual amount (does not apply to maximum out-of-pocket expense) Deductible Carryover 	\$ 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 be credited to the next calendar year deductible.				
Maximum Out-of-Pocket Expense Limit (1), (2) <ul style="list-style-type: none"> Individual (must be satisfied by each covered person) Family 	\$3,000		\$9,000	
	\$6,000		\$18,000	
Calendar Year Maximum	\$250,000 per covered person			
Lifetime Maximum Benefit	\$1,000,000 per covered person			
Preventive Care <ul style="list-style-type: none"> Well baby care through age 5 Adult and adolescent preventive and screening services (4) Childhood immunizations 	80%		60% after deductible	
Physician Services <ul style="list-style-type: none"> Office visits (includes diagnostic lab and X-ray) Allergy testing, injections and serum Inpatient services Outpatient services (includes surgery) 	80% after deductible		60% after deductible	
Hospital Services <ul style="list-style-type: none"> Inpatient care Outpatient surgery – facility Outpatient nonsurgical Emergency room (including physician visits) 	80% after deductible		60% after deductible	
Prescription Drugs (5) <ul style="list-style-type: none"> Benefit for each prescription or refill (up to 30-day supply) 	70% after deductible		50% after deductible	
Other Medical Services <ul style="list-style-type: none"> Home health care (up to 30 visits in a 12 month period) (6) Durable medical equipment (6) Hospice (6) Complications of pregnancy and sick baby services Transplant services (organ) (6), (7) 	80% after deductible		60% after deductible	
	80% after deductible		60% after deductible (subject to separate out-of-pocket maximum of \$35,000 per calendar year)	
Mental Health <i>(includes mental disorders, alcohol and chemical dependence)</i> <ul style="list-style-type: none"> Inpatient (10 days per calendar year maximum) Outpatient therapy (20 visits per calendar year maximum) 	50% after deductible		50% 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.

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) When you obtain care from nonparticipating providers:
- 50 percent of your payment toward the deductible is credited to the deductible for participating providers.
 - 50 percent of your out-of-pocket costs are credited to the out-of-pocket maximum for participating providers.
- Once you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.

- (2) 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 nonparticipating providers, prescription drugs or mental health services.
- (3) Two family members must meet their individual deductible, depending on the deductible amount selected.
- (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.

- (7) Eligible transplants:
- a. cornea transplants
 - b. kidney transplants
 - c. liver transplants for children under age 8 years
 - d. bone marrow transplants for children under age 18
 - e. evaluation, treatment and therapy involving the use of myeloablative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support for children under age 18 years.

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 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 that was present before the covered person's effective date of coverage 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

Benefits will not be provided for any of the following:

1. Services, supplies, or treatment provided prior to the effective date or after the termination date of coverage;
2. Charges in connection with a work-related injury or sickness for which coverage is provided under any state or federal worker's compensation, employer's liability, or occupational disease law; Services, supplies, or treatment for which coverage is provided under any motor vehicle no-fault plan;
3. Services, supplies, or treatment for injury or sickness resulting from war or any act of war whether declared or undeclared, from service in the military of any country, or sustained while committing a felony or engaging in an illegal occupation;
4. Services, supplies, or treatment for which benefits are provided by a governmental unit;
5. Services, supplies, or treatment for which no charge is made or for which the person is not required to pay;
6. Services or supplies not incident to or necessary for the treatment of injury or sickness or which are not medically necessary, as determined by us; treatment or prevention of an injury or sickness, including mental illness, by means of treatments, procedures, techniques, or therapy outside generally accepted health care practice;
7. Investigative/experimental technology, treatment, procedure, facility, equipment, drug, device or supply, "technology," which does not meet the criteria stated in the policy;
8. Services in connection with any transplant of any whole organ or part thereof, live or cadaver, bone marrow, either as donor or recipient, or any artificial organ, except for cornea transplants, kidney transplants, liver and bone marrow transplants for children under age 18, and evaluation, treatment and therapy involving the use of myeloablative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support for children under age 18;
9. Custodial care as defined in the policy;
10. Services, supplies, or treatment in connection with cosmetic or reconstructive procedures except as stated in the policy;
11. Dental services, except for dental injury;
12. Eyeglasses, contact lenses and/or servicing of eyeglasses and/or contact lenses, except for contact lenses for keratoconus or post-cataract surgery; vision testing, vision training, radial keratotomy, laser and any surgical correction of errors of refraction;
13. Foot care services except as provided for in the policy;
14. Drugs and medicines which do not bear the legend "Caution -- federal law prohibits dispensing without a prescription" and/or which are not dispensed by a licensed pharmacist;
15. Charges in connection with jaw realignment procedures; charges in connection with treatment of temporomandibular joint (TMJ) dysfunction;
16. Treatment of obesity by means of surgical, medical or medication services and regardless of associated medical, emotional, or psychological conditions;
17. Services or supplies in connection with genetic studies;
18. Implantable contraceptives (hormonal or other); reversal of a sterilization procedure; any treatment for or diagnosis of infertility, artificial insemination, in vitro fertilization, and any other male or female dysfunction;
19. Educational service or counseling as described in the policy; treatment for mental disorders which are irreversible or for which there is little or no reasonable expectation for improvement, including mental retardation, personality disorders, and chronic organic brain disease, except for initial assessment for diagnosis of the condition;
20. Psychotherapy, counseling, or other services in connection with learning disabilities, disruptive behavior disorders, conduct disorders, psychosexual disorders, or transsexualism. This exclusion does not apply to the initial assessment for diagnosis of the condition;
21. Vitamins, special formulas, special diets, and food supplements except as provided by a hospital or skilled nursing facility during a confinement for which benefits are available, except as required by Utah law;
22. Any devices used to aid hearing, including cochlear implants, the filling of such devices and any routine hearing tests;
23. Acupuncture or acupressure;
24. Speech therapy for psychosocial speech delays;
25. Care, except urgent or emergency care, rendered outside the United States;
26. Services provided by a member of the person's immediate family or household; and
27. Autopsy procedures.

Notes

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Policy Number:
UT-70130 8/2002, et al

UT-46004-HH

Insured by Humana Insurance Company