

SUMMARY OF BENEFITS FOR COLORADO

Preferred Provider Organization (PPO)

Individual Health Insurance

HSA-Qualified
High Deductible
Health Plans



Individual Health Insurance

Created with **you** in mind
HumanaOne[®] Health Plans
The **protection** you need

You're smart about where your money goes. You're healthy and rarely use medical services. When you do, you can afford to pay for basic care. Why spend thousands in health insurance when you only need coverage in case of serious illness or injury? Save on health insurance with a HumanaOne HSA-Qualified High Deductible Health Plan.

HumanaOne was created with you in mind – self-employed individuals, small business employees and others who are not covered under a group health insurance plan to protect you when you need care and help manage your health care costs. HumanaOne understands that you pay 100 percent of your health care premiums. That's why we offer affordable insurance plans to individuals and families.



flexibility

Simplify your health insurance
and save more money.

options

Contributions into an HSA
are tax-advantaged.

The power of *one*

security

The coverage you need
at a price you can afford.

Why choose

Peace of mind

With HumanaOne®, you could have the peace of mind that comes from knowing you are protected from financial hardship that could accompany a major medical event.

- **Ample Coverage** – Five million dollars in lifetime benefits.
- **Regulated Rates** – Rates are regulated by the state where policyholders reside.
- **Rate Guarantee** – Premium rates are guaranteed for the initial 12 months as long as you stay with the same plan and reside in the same area.
- **Portable Plan Benefits** – HumanaOne provides insurance coverage if you move to another state. Your rate may change based on your ZIP code, but you won't need to reapply for benefits and risk being denied.

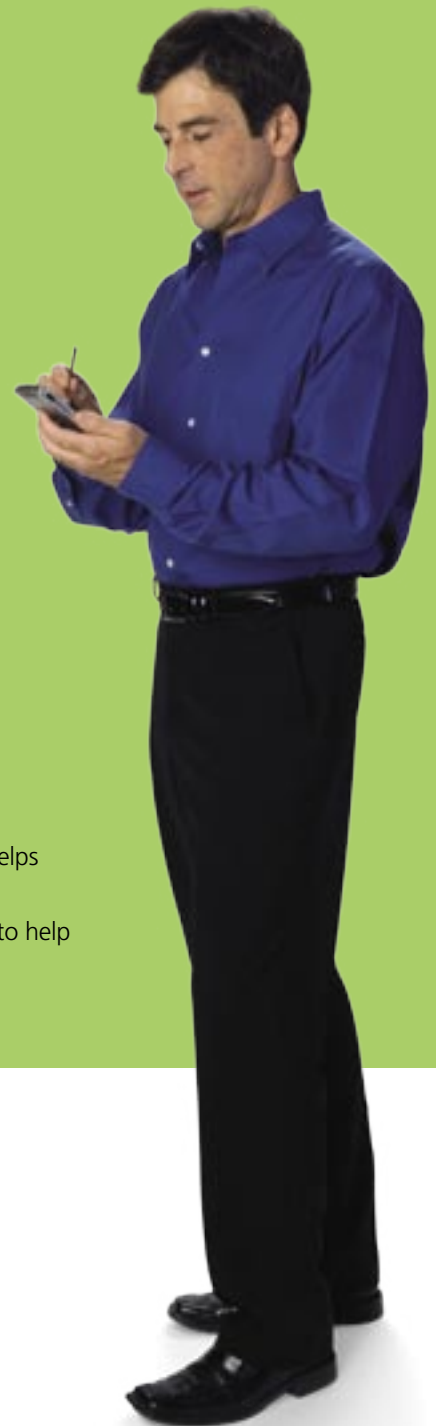
Greater savings

HumanaOne understands that when choosing a health care provider, you also need to think about costs. That's why HumanaOne continues to be committed to saving you money and time.

- **Competitive Rates** – HumanaOne offers competitive rates, saving you money for the benefits you receive.
- **Negotiated Rates** – Save over the price typically charged for medical services when you visit an in-network provider. This helps you limit out-of-pocket costs, regardless of your benefits.
- **Smarter Management** – HumanaOne provides online tools to help you manage your health care dollars more wisely.

HumanaOne – Individual Health Insurance from Humana Inc.

Humana Inc., based in Louisville, Kentucky, is one of the nation's largest publicly traded health benefit companies with over 9 million members. Humana delivers health insurance coverage to employer groups, government-sponsored plans and individuals. Humana's experience, nationwide presence and ability to secure cost-savings discounts are shared with HumanaOne members.



HumanaOne®?

Your personal Website

Get the most out of your plan with *MyHumana* – a password-protected, personal home page available any time, any where. *MyHumana* offers powerful tools designed to help you manage your medical costs and understand your plan more effectively. Some consumers could save hundreds of dollars by making more informed choices. Use *MyHumana* to:

- Review your plan benefits and check claims status.
- Track your deductible balance and out-of-pocket medical expenses.
- Reduce your prescription drug costs by researching alternatives.
Consult with your physician before changing prescription drugs.
- Search for an in-network primary care physician or specialist.
- Research a medical condition.

Customer care

HumanaOne's commitment to customer care makes it easy for you to choose and use our health insurance with confidence.

- **Convenient Application Process** – You can apply for a health insurance plan and complementary coverage, such as life and dental insurance, through one convenient application online or telephonically.
- **Customer Service** – Receive the attention you deserve with a customer support team ready to answer questions about benefits and claims. Claim payments are delivered in a timely and accurate manner. Doctors find it easier to do business with Humana than any other insurance company, according to a study conducted by *Physicians Practice* and *athenahealth*¹.
- **Health Plan Guidance** – You will receive a health plan guide within days of your approval. This easy to follow guide helps you understand your health plan and use your benefits to the fullest.

¹ *athenahealth*. (2006, May 30). *PayerView Index ranking of health insurer performance from physicians*. Retrieved August 3, 2006, from the World Wide Web: <http://www.athenapayerview.com>

COMMON INSURANCE TERMS TO KNOW

Deductible: The total dollar amount you pay annually before the plan begins to pay for covered expenses.

Coinsurance: The set percentage of health care costs you pay after you have satisfied your yearly deductible.

Preferred Provider Organization (PPO): Humana's network of health care providers contracted to provide services at a discounted rate.

In-Network Provider: Doctor, health care facility or other health care professional that is contracted with Humana and offers discounted rates.

Out-of-Network Provider: Doctor, health care facility or other health care professional that is not contracted with Humana.

You could save nearly 50% on monthly health plan premiums*

Maybe you currently have a health plan with a low annual deductible – the amount you pay before your health insurance coverage begins. With a high deductible health plan, you may substantially lower your monthly premiums.

100/70 Plan

100% coverage for medical services

Suppose you become seriously ill or injured and require expensive and extensive medical treatments. How will you afford the cost of medical care? With HumanaOne®, you only pay up to your annual deductible for in-network covered care. After that, HumanaOne pays 100 percent of the covered cost of medical care for in-network care. Now that's peace of mind. Some limitations and exclusions apply.

80/60 Plan

80% coverage for medical services

HumanaOne also offers a high deductible health plan that pays 80 percent of the covered cost of in-network medical care once you reach your annual deductible. You only pay 20 percent for the cost of in-network care. Select this plan for a lower monthly premium. Some limitations and exclusions apply. *See page 10 for additional details.*

Other Health Plan

Pay 20% after annual deductible

Annual deductible	\$500.00
Monthly premium	\$323.86
Annual cost of insurance	\$3,890.00

HumanaOne High Deductible Health Plan*

Pay 20% after annual deductible

Annual deductible	\$2,600.00
Monthly premium	\$154.16
Annual cost of insurance	\$1,849.92

Savings

Monthly savings	\$169.70
Annual savings	\$2,040.08

* Rates quoted are based on in-network coverage for plans in Milwaukee, Wisconsin, 53226. All rates quoted are for a 40-year old female, non-tobacco user with a March 1, 2006 effective date and are examples only. Actual rates vary by ZIP code, age, gender, number of members, health conditions and other variables. All cited plans, quoted rates and examples are subject to terms and limitations of the policy. Tax benefits cited are examples only and may vary by state. Consumers should consult a licensed tax professional for tax advice.

Combine your plan with a Health Savings Account (HSA)

You can combine the affordability and simplicity of the high deductible health plan with the tax advantages and financial control of an HSA. Pay for out-of-pocket qualified medical expenses incurred under your high deductible health plan, including expenses that apply toward your deductible using an HSA. You can use an HSA to save up to the amount of your health plan's annual in-network deductible.

Contributions to an HSA are tax deductible in most states, similar to an Individual Retirement Account (IRA). Deduct your contributions from your federal income tax return. Any earnings on the balance in your account accumulate tax-deferred. Withdrawals on savings, including earned interest, are tax-free if used for qualified medical expenses. Plus, your savings carry over every year and any interest incurred continues to accumulate tax-deferred.

Qualified Medical Expenses

Use your HSA to pay for covered medical expenses, including those that apply toward your health plan's annual deductible. You can also use your HSA to pay for qualified medical expenses that your health plan doesn't cover, such as:

- Hearing aids
- Orthodontia, dental cleanings and fillings
- Eye exams, eyeglasses, contact lenses
- Laser eye surgery
- Over-the-counter medicines

For a complete list of qualified medical services, consult IRS publication 502: "Medical and Dental Expenses" on the Internal Revenue Service Website at www.irs.gov. Individuals are responsible for compliance of HSA spending regulations.

HumanaOne®'s medical provider networks

HumanaOne health plans provide access to Humana's extensive network of doctors, pharmacies and hospitals. So, no matter where you work, live or travel throughout the continental United States, you are covered.

Special discounts

With HumanaOne, you could take advantage of several discount programs that could save you hundreds of dollars per year!

Additional options offered beyond your health insurance:

- **HumanaOne Dental Insurance*** – Insurance benefits for keeping your smile healthy and looking bright.

**Not available in all states.*

- **HumanaOne Term Life Insurance** – Extra financial security in times of need.

Eligibility

The issue age for insurance through HumanaOne is two months to 63 ½ years. For most states, the maximum age for a dependent child is 25 years if the child is a full-time student and 19 years if the child is not a full-time student.

You must be approved through medical underwriting when applying for a HumanaOne individual health plan. In general, you may be eligible if:

- You are generally in good health;
- Your height and weight is proportionate for someone of your age and gender;
- You are not pregnant or expecting a child (including fathers); and
- If older than age 55, you have had a physical exam within the past two years.

Simplify your health insurance and save more money, tax-free with an HSA

If you are self-employed, you may be eligible to deduct your health plan premiums from your federal income tax return. This means you can save even more of your hard-earned money.

HumanaOne HSA-Qualified High Deductible Health Plan

100/70 Plan

Annual deductible	\$2,600.00
Monthly premium	\$154.16
Annual cost of insurance	\$1,849.92

Savings and Qualified Medical Expenses

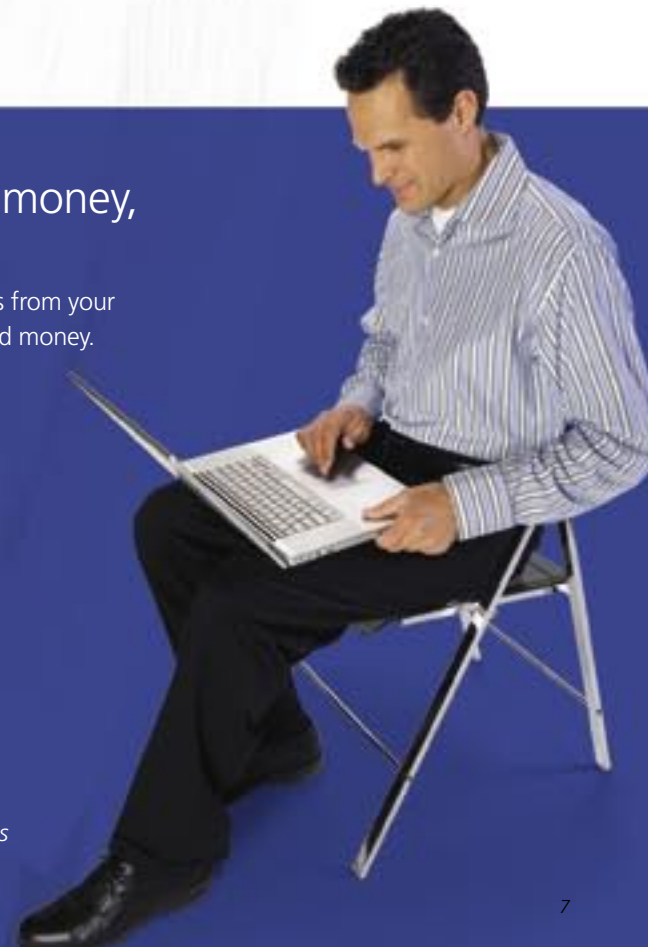
Maximum allowable contribution to an HSA	\$2,600.00
Tax-free withdrawal for qualified medical expenses	
<i>Root canal</i>	\$1,000.00
<i>Contact lenses</i>	\$500.00

Tax Deductions

Maximum allowable HSA contribution	\$2,600.00
Annual health plan premium (self-employed)	\$1,849.92

Total deductions **\$4,449.92**

x 28% tax bracket **\$1,246.00 of real tax savings**



Humana **One** COLORADO

Plan 49, Option 200

Plan pays for services at **PARTICIPATING** providers (11)

Plan pays for services at **NONPARTICIPATING** providers (12)

Mental Health

(includes mental disorders, alcohol and chemical dependence)

- Inpatient and Outpatient care *(Combined \$2,500 per calendar year maximum. Outpatient care not to exceed \$500 of the \$2,500 calendar year maximum.)*

50% after deductible

50% after deductible

Optional Dental benefits *(with teeth whitening)* (10)

You can choose any dentist, but you can save up to 30 percent on out-of-pocket costs when you visit one of the more than 75,000 dentist locations in the PPO network. You can find a dentist by visiting www.humana.com.

Preventive services plan pays **100%** no deductible

- Oral examinations
- Routine cleanings
- X-rays
- Sealants
- Topical fluoride treatment

Basic services plan pays **50%** after deductible

- Emergency exams and palliative care for pain relief
- Thumb sucking and harmful habit appliances
- Space maintainers
- Amalgam, composite fillings
- Oral surgery
- Extractions (routine)
- Non-cast stainless steel crowns
- Partial or complete denture repairs/adjustments

Teeth whitening services plan pays **50%** after deductible

- \$200 lifetime maximum

Major services plan pays **50%** after deductible

- Endodontics (root canals)
- Periodontics
- Crowns
- Inlays and onlays
- Partial or complete dentures
- Denture relines/rebases
- Removable or fixed bridgework

Orthodontia discount

Members can receive up to 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount.

Annual Deductible

- **\$50** individual
- **\$150** family

Annual maximum benefit

- **\$1,000**

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.Once you meet your single or family (if applicable) deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
- (2) 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 nonparticipating providers.
- (3) For other than single coverage, the family deductible applies. The single deductible applies to single coverage policies only.
- (4) \$300 of covered expenses per person per calendar year, subject to applicable coinsurance.
- (5) Age and/or frequency limits apply.
- (6) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- (7) Prior authorization required in order to be eligible for these benefits.
- (8) Bereavement limited to \$1,150 per family for the 12-month period following death. Nursing, social/counseling services, and certified nurses aid or delegated nursing services, limited to \$9,100 per member per benefit period.
- (9) This benefit covers well-baby charges for a hospital stay of 48 hours following a vaginal delivery and 96 hours following a Cesarean section. If delivery occurs after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning.
- (10) This is not a complete disclosure of plan qualifications and limitations. Waiting periods apply: six months on basic services and teeth whitening, 12 months on major services. Please review the specific Dental limitations & exclusions before applying for coverage.

(11) The Preferred Provider Organization (PPO) Network has an inadequate number of providers in the following counties in Colorado: Custer, Dolores, Hinsdale, Jackson, Mineral, San Juan, San Miguel.

(12) Nonparticipating providers may balance bill you for the difference between the amount paid by us and the nonparticipating providers billed charges if:

- (a) You are required to travel no more than a reasonable distance beyond the plan's service area in order to receive services from a participating provider;**
- (b) The covered person knowingly seeks services from a nonparticipating provider; and**
- (c) The nonparticipating provider is reimbursed for an amount less than the billed charge.**

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days

to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request,

within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

A copy of the Colorado Network Access plan can be provided upon request.

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.

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.

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

Humana **One** COLORADO

Plan 49, Option 201

Plan pays for services at
PARTICIPATING providers (11)

Plan pays for services at
NONPARTICIPATING providers (12)

Annual Deductible (1), (2)	Single Deductible	Family Deductible (3)	Single Deductible	Family Deductible (3)
<ul style="list-style-type: none"> Annual amount 	\$ 1,500 2,000 2,600	\$ 3,000 4,000 5,150	\$ 3,000 4,000 5,200	\$ 6,000 8,000 10,300
Maximum Out-of-Pocket Expense Limit (1), (2), (3)				
<ul style="list-style-type: none"> Individual 	\$2,000		\$8,000	
<ul style="list-style-type: none"> Family 	\$4,000		\$16,000	
Lifetime Maximum Benefit	\$5,000,000 per covered person			
Preventive Care				
<ul style="list-style-type: none"> Well-child care (including immunizations) (birth to age 13) 	80%		60%	
<ul style="list-style-type: none"> Routine annual Mammograms (5) 				
<ul style="list-style-type: none"> Routine annual PSA and digital rectal exam (5) 				
<ul style="list-style-type: none"> Routine annual physical exam (age 13 and older) (4) 	80%		Not covered	
<ul style="list-style-type: none"> Routine immunizations (age 13 to age 18) (4) 				
<ul style="list-style-type: none"> Routine Pap smears (4), (5) 				
<ul style="list-style-type: none"> Routine lab, pathology and X-ray (4) 	80% after deductible		Not covered	
Physician Services				
<ul style="list-style-type: none"> Office visits (includes diagnostic lab and X-ray) 	80% after deductible		60% after deductible	
<ul style="list-style-type: none"> Allergy testing, injections and serum 				
<ul style="list-style-type: none"> Inpatient services 				
<ul style="list-style-type: none"> Outpatient services (includes surgery) 				
Hospital Services				
<ul style="list-style-type: none"> Inpatient care 	80% after deductible		60% after deductible	
<ul style="list-style-type: none"> Outpatient surgery – facility 				
<ul style="list-style-type: none"> Outpatient nonsurgical 				
<ul style="list-style-type: none"> Newborn hospital stay (9) 				
<ul style="list-style-type: none"> Emergency room (including physician visits) 				
Prescription Drugs (6)				
<ul style="list-style-type: none"> Benefit for each prescription or refill (up to 30-day supply) 	80% after deductible		60% after deductible	
<ul style="list-style-type: none"> Mail order (90-day supply) 				
Other Medical Services				
<ul style="list-style-type: none"> Skilled nursing facility (up to 30 days per calendar year) (7) 	80% after deductible		60% after deductible	
<ul style="list-style-type: none"> Home health care (up to 60 visits per calendar year) (7) 				
<ul style="list-style-type: none"> Durable medical equipment (7) 				
<ul style="list-style-type: none"> Hospice (7), (8) 				
<ul style="list-style-type: none"> Complications of pregnancy and sick baby services 				
<ul style="list-style-type: none"> Transplant services (organ) (7) 	80% after deductible (when services are performed at a National Transplant Network provider)		60% after deductible (subject to separate out-of-pocket maximum of \$35,000 per calendar year)	

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.

Humana**One** COLORADO

Plan 49, Option 201

Plan pays for services at
PARTICIPATING providers (11)

Plan pays for services at
NONPARTICIPATING providers (12)

Mental Health (includes mental disorders, alcohol and chemical dependence)

- Inpatient and Outpatient care (Combined \$2,500 per calendar year maximum. Outpatient care not to exceed \$500 of the \$2,500 calendar year maximum.)

50% after deductible

50% after deductible

Optional Dental benefits (with teeth whitening) (10)

You can choose any dentist, but you can save up to 30 percent on out-of-pocket costs when you visit one of the more than 75,000 dentist locations in the PPO network. You can find a dentist by visiting www.humana.com.

Preventive services plan pays **100%** no deductible

- Oral examinations
- Routine cleanings
- X-rays
- Sealants
- Topical fluoride treatment

Basic services plan pays **50%** after deductible

- Emergency exams and palliative care for pain relief
- Thumb sucking and harmful habit appliances
- Space maintainers
- Amalgam, composite fillings
- Oral surgery
- Extractions (routine)
- Non-cast stainless steel crowns
- Partial or complete denture repairs/adjustments

Teeth whitening services plan pays **50%** after deductible

- \$200 lifetime maximum

Major services plan pays **50%** after deductible

- Endodontics (root canals)
- Periodontics
- Crowns
- Inlays and onlays
- Partial or complete dentures
- Denture relines/rebases
- Removable or fixed bridgework

Orthodontia discount

Members can receive up to 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount.

Annual Deductible

- **\$50** individual
- **\$150** family

Annual maximum benefit

- **\$1,000**

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 single or family (if applicable) deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
- (2) 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 nonparticipating providers.
- (3) For other than single coverage, the family deductible applies. The single deductible applies to single coverage policies only.

- (4) \$300 of covered expenses per person per calendar year, subject to applicable coinsurance.
- (5) Age and/or frequency limits apply.
- (6) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- (7) Prior authorization required in order to be eligible for these benefits.
- (8) Bereavement limited to \$1,150 per family for the 12-month period following death. Nursing, social/counseling services, and certified nurses aid or delegated nursing services, limited to \$9,100 per member per benefit period.
- (9) This benefit covers well-baby charges for a hospital stay of 48 hours following a vaginal delivery and 96 hours following a Cesarean section. If delivery occurs after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning.
- (10) This is not a complete disclosure of plan qualifications and limitations. Waiting periods apply: six months on basic services

and teeth whitening, 12 months on major services. Please review the specific Dental limitations & exclusions before applying for coverage.

- (11) **The Preferred Provider Organization (PPO) Network has an inadequate number of providers in the following counties in Colorado: Custer, Dolores, Hinsdale, Jackson, Mineral, San Juan, San Miguel.**
- (12) **Nonparticipating providers may balance bill you for the difference between the amount paid by us and the nonparticipating providers billed charges if:**
 - (a) **You are required to travel no more than a reasonable distance beyond the plan's service area in order to receive services from a participating provider;**
 - (b) **The covered person knowingly seeks services from a nonparticipating provider; and**
 - (c) **The nonparticipating provider is reimbursed for an amount less than the billed charge.**

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who

has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in

coverage under or who is covered by a health benefit plan of the carrier.

A copy of the Colorado Network Access plan can be provided upon request.

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.

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 which was diagnosed or treated during the 12-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.
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; tubal ligation; 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. 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.
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.
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 while sane.
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.

Dental Limitations and Exclusions

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

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

1. The course of any occupation or employment for compensation, profit or gain, for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or where such coverage was available, regardless of whether the coverage was actually applied for.
2. Services and supplies for which no charge is made, or for which the covered person would not be required to pay in the absence of insurance.
3. Services furnished by or payable under any plan or law through any Government or any political subdivision.
4. Services furnished by any hospital or institution owned or operated by the United States Government.
5. War or any act of war, whether declared or not; or any act of international armed conflict or any conflict involving armed forces of any international authority.
6. Completion of forms or failure to keep an appointment with a dentist.
7. Cosmetic dentistry, except as stated in the policy.
8. Any service related to altering vertical dimension; restoration or maintenance of occlusion; splinting teeth; replacing tooth structures lost as a result of abrasion, attrition or erosion; or bite registration or bite analysis.
9. Bone grafts, regeneration, augmentation or preservative procedures in edentulous sites.
10. Implants, including any crowns or prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with it; or other customized attachments.
11. Infection control.
12. Fees for treatment by other than a dentist, except as stated in the policy.
13. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
14. Prescription drugs or pre-medications, whether dispensed or prescribed.
15. Any service not listed as a covered expense.
16. Any service not considered a dental necessity, does not offer a favorable prognosis, does not have uniform professional endorsement, or is experimental or investigational in nature.
17. Expenses incurred prior to the effective date or after the date coverage is terminated, except for any extension of benefits.
18. Services provided by a person who ordinarily resides in the covered person's home or who is a family member.
19. Charges in excess of the reimbursement limit for the service or supply.
20. Treatment as a result of an intentionally self-inflicted injury or bodily illness, while sane or insane.
21. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with impression or placement of a restoration, charged as a separate service.
22. Repair and replacement of orthodontic appliances.

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 give in this document, terms and conditions of the policy will govern.



Policy Number:
GN-70129 8/2002, et al
CO-70141-HD et al

Insured by Humana Insurance Company or HumanaDental Insurance Company

CO-46073-HH