

Humana **One** OHIO

AUTOGRAPH Total/HSA

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 	\$ 2,000 3,000 4,000 5,200	\$ 4,000 6,000 8,000 10,400	\$ 4,000 6,000 8,000 10,400	\$ 8,000 12,000 16,000 20,800
Maximum Out-of-Pocket Expense Limit (1), (2), (3) <ul style="list-style-type: none"> Individual Family 	\$0		\$6,000 \$12,000	
Lifetime Maximum Benefit	\$2,000,000 per covered person			
Preventive Care <ul style="list-style-type: none"> Child health supervision services (birth to age one, up to \$500 per calendar year; includes annual hearing screening benefit \$75 maximum) Child health supervision services (ages 1 to 8, up to \$150 per calendar year) Routine physical exam, immunizations (age 9 to age 18) and PSA (4), (5), (6) Routine Pap smears (6) Mammogram (limited to 130% of medicare reimbursement rate) (6) Routine lab, pathology and X-ray (4), (5) 	100%		70% 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) (7) 	100% after deductible		70% after deductible	
Hospital Services <ul style="list-style-type: none"> Inpatient care Outpatient surgery – facility (7) Outpatient nonsurgical Emergency room (including physician visits) 	100% after deductible		70% after deductible	
Other Medical Services <ul style="list-style-type: none"> Skilled nursing facility (up to 30 days per calendar year) (8) Home healthcare (up to 60 visits per calendar year) (8) Durable medical equipment (8) Hospice (8), (9) Complications of pregnancy and sick baby services Transplant services (organ) (8) 	100% after deductible		70% after deductible	
	100% after deductible (when services are performed at a National Transplant Network provider)		70% after deductible (limited to \$35,000 per covered transplant)	
Prescription Drugs (12)	Discount card included (This added value feature is not insurance.)		Not covered	

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.

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Optional Benefits (10)

- Lifetime maximum benefit
- \$500 Supplemental Accident Benefit
(Treatment must be provided within 90 days of the injury.)
- \$1,000 Supplemental Accident Benefit
(Treatment must be provided within 90 days of the injury.)

\$5,000,000 per covered person

First \$500 per accident at **100%**, then base plan benefits apply

First \$1,000 per accident at **100%**, then base plan benefits apply

Optional Dental benefits (with teeth whitening) (11)

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.

- (3) For other than single coverage, the family deductible applies. The single deductible applies to single coverage policies only.
- (4) Benefit payable after 90-day waiting period for preventive care.
- (5) \$300 of covered expenses per person per calendar year, subject to applicable coinsurance.
- (6) Age and/or frequency limits apply.
- (7) 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).
- (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.
- (10) These benefits are optional and can be added to your plan for an additional cost. Optional benefits may not be available in all areas.
- (11) 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.
- (12) There is no coverage for retail and/or mail order prescription drugs unless stated in the policy.

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, or which produced signs or symptoms that would cause an ordinarily prudent person to seek treatment, 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 or which are experimental, investigational or for research purposes.
2. Services not authorized or prescribed by a healthcare 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. Infertility services.
9. Pregnancy and well-baby expenses.
10. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
11. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses; hearing aids; dental exams.
12. Hearing and eye exams (except for hearing screenings for newborns to 24-months of age); and physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests.
13. Services received in an emergency room unless required because of emergency care.
14. Dental services (except for dental injury), appliances or supplies.
15. War or any act of war, whether declared or not; commission or attempt to commit a civil or criminal battery or felony.
16. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the policy.
17. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat sickness or injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures.
18. 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.
19. Foot care services.
20. Charges for nonmedical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
21. 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.
22. Hair prosthesis, hair transplants or implants and wigs.
23. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck neurological disorder.
24. 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, except for certain professions or activities as stated in the policy.
25. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.
26. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
27. Charges covered by other medical payments insurance.
28. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
29. 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.
30. Mental health including mental disorders, alcohol and chemical dependency.
31. Spinal manipulations and spinal adjustment modalities.
32. Prescription drugs except drugs provided or administered while confined in a hospital or skilled nursing facility, by a home health agency or by a healthcare practitioner during an office visit.

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, unless legally required to pay.
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.