



## Monogram: Total Plus Rx - Indiana

BENEFIT CATEGORY	NETWORK: You Pay	NON-NETWORK: You Pay
<b>Deductible Options</b> <sup>1</sup> - per calendar year - copayments do not apply		
<ul style="list-style-type: none"> <li>Individual</li> </ul>	\$7,500	\$15,000
<ul style="list-style-type: none"> <li>Family (two family members must each meet the individual deductible)</li> </ul>	\$15,000	\$30,000
<b>Deductible Carryover Applies</b> - 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.		
<b>Office Visit Copayment</b>	Not applicable	Not applicable
<b>Coinsurance out-of-pocket limit</b> <sup>1</sup> - per calendar year - deductibles and copayments do not apply		
<ul style="list-style-type: none"> <li>Individual</li> </ul>	\$0	\$5,000
<ul style="list-style-type: none"> <li>Family</li> </ul>	\$0	\$10,000
BENEFIT CATEGORY	NETWORK: Plan Pays	NON-NETWORK: Plan Pays
<b>Preventive Care</b>		
<ul style="list-style-type: none"> <li>Preventive Office Visits<sup>2</sup></li> <li>Child Immunizations to age 18<sup>2</sup></li> <li>Pap Smear<sup>2</sup></li> <li>Mammogram</li> <li>Prostate Screening<sup>2</sup></li> <li>Colorectal Cancer Screening, Related Exams and Lab Tests</li> </ul>	100%	Not covered
<ul style="list-style-type: none"> <li>Preventive Lab and X-ray<sup>2</sup></li> </ul>	100% after deductible	Not covered
<b>Physician Services</b>		
<ul style="list-style-type: none"> <li>Office Visits (including allergy injections)</li> <li>Diagnostic Lab and X-Ray<sup>3</sup></li> <li>Allergy Testing</li> <li>Allergy Serum</li> <li>Inpatient and Outpatient Services</li> <li>Surgery</li> </ul>	100% after deductible	75% after deductible
<b>Facility Services</b>		
<ul style="list-style-type: none"> <li>Inpatient and Outpatient Services</li> <li>Outpatient Surgery</li> </ul>	100% after deductible	75% after deductible
<ul style="list-style-type: none"> <li>Emergency Services (copayment waived if admitted)</li> </ul>	100% after \$125 copayment per visit and deductible	75% after \$125 copayment per visit and deductible

BENEFIT CATEGORY	NETWORK: Plan Pays		NON-NETWORK: Plan Pays	
<b>Rx4 Prescription Drug<sup>4</sup></b> - medical out-of-pocket maximum does not apply <ul style="list-style-type: none"> <li>• Deductible per Individual</li> <li>• Copayment for each Prescription or Refill</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Copayment Maximum (applies to Level 4 drugs only)</li> <li>• Benefit per Prescription or Refill</li> <li>• Mail Order (up to 90-day supply)</li> </ul>	Separate \$1,000 deductible (does not apply to Level 1 drugs)			
	Level 1: \$15 copayment (deductible does not apply) Level 2: \$40 copayment Level 3: \$65 copayment Level 4: 25% copayment			
	\$2500 per individual per calendar year			
	100% after prescription copayment	70% after prescription copayment		
	100% after 3x retail copayment	70% after 3x retail copayment		
<b>Other Medical Services</b> - prior authorization required in order to be eligible for these benefits <ul style="list-style-type: none"> <li>• Skilled Nursing Facility (up to 30 days per calendar year)</li> <li>• Hospice<sup>5</sup></li> <li>• Home Health Care (up to 60 visits per calendar year)</li> <li>• Durable Medical Equipment</li> <li>• Pregnancy Complications and Sick Baby Services (no prior authorization required)</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Transplant Services</li> </ul>	100% after deductible		75% after deductible	
	100% after deductible when services are received from a Humana Transplant Network provider		75% after deductible - covered expenses are limited to a maximum allowance of \$35,000 per transplant	
<b>Lifetime Maximum Benefit</b>	\$2,000,000 per covered person			
<b>Mental Health<sup>6</sup></b>				
<ul style="list-style-type: none"> <li>• Inpatient Services</li> <li>• Outpatient and Office Therapy Sessions</li> </ul>	100% after deductible		75% after deductible	
<b>Chemical and Alcohol Dependency</b> - services other than for treatment of mental illness - \$2,500 per calendar year - medical out-of-pocket maximum does not apply <ul style="list-style-type: none"> <li>• Inpatient Services</li> <li>• Outpatient and Office Therapy Sessions (outpatient services not to exceed \$500 of the total benefit)</li> </ul>	50% after deductible		50% after deductible	
<b>Optional Benefits</b> - these are available to add for an additional cost - medical out-of-pocket maximum does not apply to drug coverage <ul style="list-style-type: none"> <li>• Prescription Drug Deductible</li> <li>• Lifetime Maximum</li> <li>• Supplemental Accident Benefit (\$500 or \$1000) (treatment must be provided within 90 days of the injury)</li> </ul>				
	Not available with this plan			
	Increase to \$5,000,000 per covered person			
	First \$500 per accident at 100%, then base plan benefits apply, or First \$1,000 per accident at 100%, then base plan benefits apply			

**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 non-network providers:
  - 50% of your payment toward the deductible is credited to the deductible for network providers.
  - 50% of your out-of-pocket costs are credited to the out-of-pocket maximum for network providers.Once you meet your deductible and out-of-pocket expense limits, the plan pays 100% for covered services.
2. Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance.
3. MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
4. If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement. The covered person will also be responsible for 30% of the actual charge made by the dispensing pharmacy, after the applicable copayment.  
The plan classifies prescriptions in one of four levels:
  - **Level 1:** Low-cost generic and brand-name drugs
  - **Level 2:** Higher-cost generic and brand-name drugs
  - **Level 3:** Higher-cost brand name drugs that may have generic or brand-name alternatives on levels one or two, saving you money. This level also includes some self-administered injectable medications.
  - **Level 4:** Self-administered injectable medications, and high-technology drugs
5. 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.
6. Including chemical and alcohol dependency when services are required in the treatment of a mental illness.

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## Payments

Network 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 non-network providers are based on maximum allowable fees, as defined in your policy.

Non-network 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.

Network 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.

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## Medical Limitations and Exclusions

This is an outline of the limitations and exclusions for the HumanaOne individual health plan listed above. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Your policy is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the policy.

### Eligibility

The issue ages for HumanaOne individual health plans are two months to 64.5 years. The maximum age for a dependent child is 25 years if the child is a full-time student and 24 years if the child is not a full-time student.

### Pre-existing conditions

A pre-existing condition is a sickness or bodily injury which was treated within the 24-month period prior to the covered person's effective date of coverage or which produced symptoms that would cause an ordinarily prudent person to seek medical diagnosis or treatment within the 12-month period prior to 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 Humana. Humana 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; routine 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, unless qualified as morbid obesity
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
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. Attempted suicide or intentionally self-inflicted injury, whether sane or insane
26. Charges covered by other medical payments insurance
27. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes
28. 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
29. Any drug, medicine or device which is not FDA approved
30. Contraceptives other than oral, including implant systems and devices regardless of the purpose for which prescribed
31. Medications, drugs or hormones to stimulate growth
32. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered injury or sickness
33. 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
34. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription
35. Drugs used in treatment of nail fungus
36. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order
37. Vitamins, dietary products and any other nonprescription supplements
38. 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

Insured by Humana Insurance Company Applications are subject to approval. Waiting periods, limitations and exclusions apply. The HumanaOne brand of individual products are insured by subsidiaries of Humana, Inc.

**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.**