HumanaOne®

Individual Health Insurance

Summary of Benefits for Florida

Humana One®

FL-46001-HH 7/04

Easy to Choose

When it comes to individual health insurance, the Humana*One* Individual Health Plan is an easy choice. We've simplified our plan to include more of the benefits you'd expect from group insurance – but tailored for individuals and families. With Humana*One* health plans, not only do you get **five million dollars worth of lifetime coverage, preventive care, prescription drug and emergency room care benefits, but also online tools and resources** and an **extensive network of providers**. Plus, Humana*One* health plans are insured by subsidiaries of Humana Inc., one of the nation's largest publicly traded health benefits companies, with over 6.6 million members nationwide.

With the Humana*One* Individual Health Plan, you have a choice of annual deductible options and additional benefits such as:

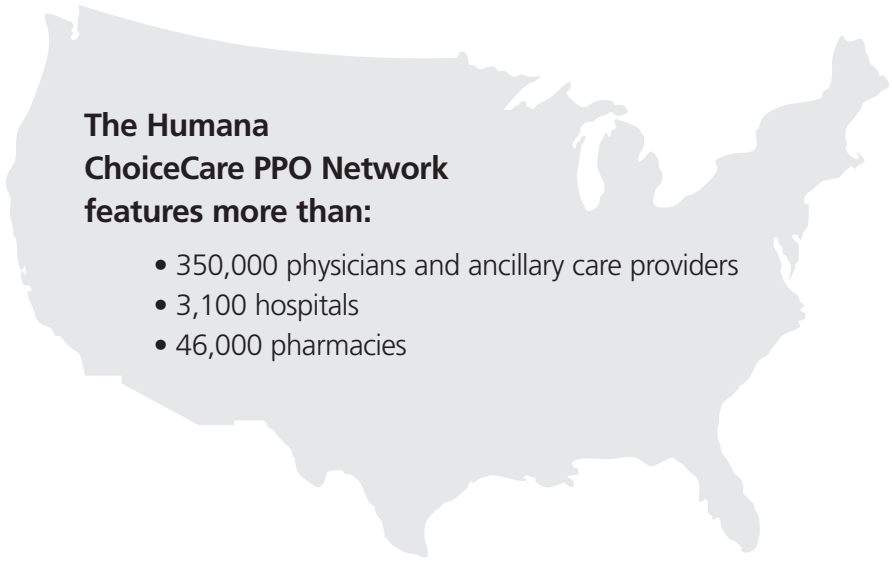
- **Zero deductible prescription drug option** – no deductible is required to be met before plan benefits are payable
- **Maternity benefit option** – provides benefits for maternity and routine newborn care
- **Office visit copayment option** – office visit benefits are payable at 100 percent after a $25 copayment for primary care physician visits and $40 copayment for a specialist visit (limited to four total visits per calendar year).
- **$20,000 term life insurance option** - extra financial security for you and for your spouse.

(Not all options are available in all states, waiting periods may apply for some benefits.)

Easy to Use

Nationwide network of providers

Humana*One* health plans provide access to doctors, pharmacies and hospitals nationwide through the Humana/ChoiceCare PPO Network. So, no matter where you work or travel throughout the continental U.S., you're covered. What's more, Humana*One* health plans give you the freedom to see the doctor of your choice. You receive the most from your plan when visiting a doctor, hospital or pharmacist in the network, but you're still covered if you choose an out-of-network provider.



The Humana ChoiceCare PPO Network features more than:

- 350,000 physicians and ancillary care providers
- 3,100 hospitals
- 46,000 pharmacies

Prescription drug benefits

When your doctor prescribes a drug that's covered by your Humana*One* health plan, you'll find the drug in one of four levels. And no matter which level contains your drug, your prescription drug costs are covered to some degree (see the following Summary of Benefits for specific benefit information). The levels are:
Level One – low-cost generic and brand-name drugs.
Level Two – higher-cost generic and brand-name drugs.
Level Three – higher-cost, mostly brand-name alternatives to drugs on Level One and Two.
Level Four – self-administered, injectable medications and high-technology drugs.

For your convenience, you may also receive a maximum 90-day supply per prescription or refill through the mail (maximum 30-day supply for self administered injectable drugs) by purchasing medications through a participating mail-order pharmacy.

www.humana.com

Humana*One* health plan members have 24-hour access to valuable tools and resources on **www.humana.com**. All registered members have a personal page called *My*Humana, where you can:

- Locate a doctor, hospital or pharmacy by using Physician Finder *Plus*.
- Learn how to reduce prescription drug costs through *My*Prescriptions.
- Check benefits and claims status with *My*Plan Benefits.
- Use the condition center to aid in monitoring and managing your health.

Humana*Health*® Programs and Services

Humana*One* health plans offer special educational programs and supportive resources to members with certain medical situations and/or chronic conditions:

- **Humana*Beginnings***® combines education and informative mailings to help expectant mothers learn about their pregnancy, follow their baby's development, and practice healthy habits along the way.
- **Personal Nurse**® provides guidance to resources and tools to help members manage their condition and understand their health care options. The service is available to members we believe may benefit most from additional support.
- **HumanaFirst**® is a free, 24-hour nurse assistance line members can use to speak with a registered nurse.

Easy to Apply

With Humana*One*, you don't have to wait weeks for coverage you need now! With just a phone call, you can begin the application process. You may even qualify for same day approval.

One more reason Humana*One* health plans are a great choice!

Initial 12-month rate guarantee

Put your mind at ease with our initial 12-month rate guarantee. Not only do our plans eliminate rate increases based merely on claims, they also provide lock-in premium amounts that stay the same through the first year (provided your benefit choice and location remain the same).

Humana*One*

FLORIDA Plan 49, Option 001

		Plan pays for services at ***PARTICIPATING*** providers		Plan pays for services at ***NONPARTICIPATING*** providers	
Annual Deductible (1), (2)	• Annual amount *(does not apply to maximum out-of-pocket expense)*	**Single Deductible**	**Family Deductible** (3)	**Single Deductible**	**Family Deductible** (3)
		$ 500	$ 1,500	$ 1,000	$ 3,000
		1,000	3,000	2,000	6,000
		2,500	5,000	5,000	10,000
		5,000	10,000	10,000	20,000
	• Deductible carryover	Covered expenses incurred in the last three months of the calendar year and applied to the deductible will also be credited to the next calendar year deductible.			
Maximum Out-of-Pocket Expense Limit (1), (2)	• Individual *(must be satisfied by each covered person)*	$2,000		$8,000	
Lifetime Maximum Benefit		$5,000,000 per covered person			
Preventive Care	• Routine annual physical exam (4), (5) • Routine immunizations *(ages 16 to 18)* (4), (5) • Routine Pap smears and PSA (4), (5), (6)	**80%**		**50%** after deductible	
	• Routine mammograms (6)	**100%**		**100%**	
	• Routine lab, pathology and X-ray (4), (5)	**80%** after deductible		**50%** after deductible	
	• Child health supervision services *(includes immunizations; birth to age 16; maximum of 18 visits per covered child)*	**80%**		**60%**	
Physician Services	• Office visits *(includes diagnostic lab and X-ray)* • Allergy testing, injections and serum • Inpatient services • Outpatient services *(includes surgery)* (7)	**80%** after deductible		**60%** after deductible	
Hospital Services	• Inpatient care • Outpatient surgery – facility (7) • Outpatient nonsurgical	**80%** after deductible		**60%** after deductible	
	• Emergency room *(including physician visits)*	**80%** after $75 copayment per visit and deductible *(copayment waived if admitted)*		**60%** after $75 copayment per visit and deductible *(copayment waived if admitted)*	
Prescription Drugs (8)	• Prescription drug deductible *(Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts.)* (2)	$500 prescription drug deductible per individual		$500 prescription drug deductible per individual	
	• Benefit for each prescription or refill *(up to 30-day supply)*	**100%** after:		**70%** after:	
	– Level One - lowest copayment for lowest cost generic and brand-name drugs	$10 copayment after prescription drug deductible		$10 copayment after prescription drug deductible	
	– Level Two - higher copayment for higher cost generic and brand-name drugs	$30 copayment after prescription drug deductible		$30 copayment after prescription drug deductible	
	– Level Three - higher copayment than Level Two for higher cost, mostly brand-name drugs that may have generic or therapeutic equivalents in Levels One or Two	$50 copayment after prescription drug deductible		$50 copayment after prescription drug deductible	
	– Level Four - highest copayment for high-technology drugs *(certain brand-name drugs, biotechnology drugs and self-administered injectable medications)*	**25%** copayment after prescription drug deductible up to $2,500 maximum out-of-pocket per calendar year		**25%** copayment after prescription drug deductible up to $2,500 maximum out-of-pocket 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.

FLORIDA Plan 49, Option 001		**Plan pays for services at *PARTICIPATING* providers**	**Plan pays for services at *NONPARTICIPATING* providers**
Prescription Drugs (8) *(continued)*	• Mail order *(90-day supply)*	**100%** after three times the retail copayment	**70%** after three times the retail copayment
Other Medical Services	• Skilled nursing facility *(up to 30 days per calendar year)* (9) • Home health care *(up to 60 visits per calendar year)* (9) • Durable medical equipment (9) • Hospice (9) (10) • Physical medicine, chiropractic services *(up to combined maximum of 20 visits per calendar year)* • Complications of pregnancy and sick baby services • Dental procedures and anesthesia • Outpatient self-management training and education for diabetes • Diagnosis and treatment of osteoporosis • Cleft lip and palate, including speech therapy, audiology and nutrition services *(covered children under age 18)* • Outpatient post-surgical follow-up care for masectomy • Enteral formulas for inherited diseases of amino and organic acids to age 25 *(up to $2500 per calendar year per covered person)*	**80%** after deductible	**60%** after deductible
	• Ambulance *(up to $15,000 maximum per calendar year)*	**80%** after deductible	**80%** after deductible
	• Transplant services *(organ)* (9)	**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)*
Mental Health *(includes mental disorders, alcohol and chemical dependence; waiting period applies)* (4)	Outpatient mental health maximum reduces inpatient mental health maximum • Inpatient *(up to $2,500 maximum per calendar year)* • Outpatient therapy *(up to $500 maximum per calendar year)*	**50%** after deductible	**50%** after deductible
Optional Benefits (11)	• Prescription drug, no deductible	Under this option, no deductible is required to be met before plan benefits are payable.	
	• Maternity including routine newborn care and post-hospital follow-up *(waiting period applies)* (2), (4)	**60%** after $500 maternity deductible	**40%** after $1,000 maternity deductible
	• Office visit copayment option *(includes office diagnostic tests, lab and X-rays, paid at **100%** up to $100 per calendar year. Does not apply to preventive/routine care)* (2), (12)	**100%** after $25 copayment for primary care physician and $40 copayment for specialist limited to four combined visits *(primary care physician and specialist)* per calendar year. After four visits, plan pays **80%** after deductible	**60%** after deductible

To be covered, services must be medically necessary and may be subject to pre-existing condition limitations. 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, mental health services or maternity, if the optional maternity benefit is selected.

(3) Two or three family members must meet their individual deductible, depending on the deductible amount selected.

(4) Benefit payable after 90-day waiting period for preventive care and 12 month waiting period for mental health and maternity.

(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) If a nonparticipating pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.

(9) Prior authorization required in order to be eligible for these benefits.

(10) Bereavement limited to 15 visits per family per lifetime, Medical Social Services limited to $100 per family per lifetime.

(11) These benefits are optional and can be added to your plan for an additional cost.

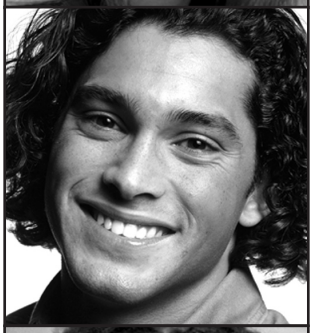
(12) This benefit does not cover MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies. Primary care physicians include family practitioner, general practitioner, pediatrician or internist; specialist contains any other participating physician. Please contact Customer Service for details.

For information on plans available to HIPAA eligible individuals, please call (800) 833-6916.

Payments - Plan benefits are paid based on the maximum allowable fees, as defined in your policy. Participating providers agree to accept the maximum allowable fees, as listed in negotiated payment schedules, as payment in full.

For services rendered by nonparticipating providers, the member is responsible for charges exceeding the maximum allowable fees as explained in your policy.

Participating primary care and specialist physicians and other providers in Humana's networks are <u>not</u> 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.



A variety of plan types

From individual health coverage to term life insurance, Humana*One* offers a variety of plan types to fit your needs.

Humana*One* Term Life Insurance – Simple, convenient, affordable financial protection for your loved ones with the following advantages:

- Flexible coverage amounts from $25,000 to beyond $1 million.
- Renewable to age 95.
- Easy and convenient application process that can be done in conjunction with a health application, or by itself. In most cases, a medical exam is not required for coverage through $150,000.
- Premiums are level for 10, 15 or 20 years and guaranteed to age 95.

In addition to these important features, Humana*One* Term Life Insurance also gives you the ability to select several different optional riders. Depending on your circumstances, these riders can make this coverage even more valuable to you and your family:

- **Premium Waiver** pays your policy premium if you are totally disabled. It is available for individuals ages 18-55, and coverage ends on the policy renewal date on or after the insured's 60th birthday. If the insured is totally disabled at this time, then coverage ends when the insured is no longer totally disabled.
- **Accidental Death** provides an additional benefit equal to the amount of the base policy. Available for those ages 18-55, and coverage ends on the policy renewal date on or after the insured's 65th birthday.
- **Children's Term Coverage** provides $5,000 of coverage for each child, and one premium covers all children in the family. Available for purchase by those ages 18-55. Coverage for a child ends on the child's 19th birthday. Coverage for all children ends on the policy renewal date on or after the insured's 65th birthday.

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-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 ordinary prudent person to seek medical advice, care or treatment, during the 24-month period before the covered person's effective date of coverage. Routine follow-up care to determine the reoccurence of breast cancer does not constitute medical advice, care or treatment. 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 covered 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; 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. Routine physical, hearing and eye examinations for occupation, employment, school, travel, purchase of insurance or premarital tests.
22. Dental services (except for dental injury), appliances or supplies.
23. War or any act of war, whether declared or not; commission or attempt to commit a civil or criminal battery or felony.
24. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the policy.
25. Obesity except for morbid obesity.
26. 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.
27. Foot care services.
28. Charges for nonmedical purposes or used for environmental control or enhancement (whether or not prescribed by a health care practitioner).
29. 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.
30. Hair prosthesis, hair transplants or implants and wigs.
31. Temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorders, and any treatment for jaw, joint or head and neck neuromuscular disorder unless diagnostic and/or surgical procedures are medically necessary to treat conditions caused by congenital or developmental deformity, disease or injury.
32. Services for an injury or illness for which benefits are paid by Workers' Compensation or similar benefits.
33. 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.
34. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
35. Charges covered by other medical payments insurance.
36. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes, except as stated in the policy.
37. 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.

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the terms and conditions of the policy will govern.

Policy number: FL-70129 8/2002 et al
FL-46001-HH 7/04

Insured by Humana Health Insurance Company of Florida, Inc.