



Indiana

Autograph™ Total/HSA



# A plan that fits your lifestyle and budget

## With Total HSA, get a great blend of features and benefits including:

- Four deductible options
- 100% coverage for most covered in-network medical costs after deductible
- A large network you can rely on
- Coverage for annual exams and physicals
- Optional benefits like life coverage at an additional cost
- An optional Health Savings Account (HSA)

### Add a Health Savings Account (HSA) and save more money, tax-free!\*

You can combine the affordability and simplicity of this Autograph plan with the tax advantages of a savings account specifically used for health expenses. This combination means you'll save on your healthcare premiums and reduce your taxable income.

Contributions are tax-free, grow tax-deferred and earn interest so when you use the funds you won't have to pay taxes for qualified medical expenses. Also, you don't lose the money you saved if it isn't spent the year you contribute to your HSA.

HumanaOne can provide convenient access to banking partners where you can establish your HSA account. If you prefer, you can select your own bank.

\*Varies by state

# HumanaOne INDIANA

## Autograph Total/HSA

	Plan pays for services at <b>NETWORK</b> providers		Plan pays for services at <b>NON-NETWORK</b> providers	
<b>Annual Deductible</b> (1), (2)	<b>Single Deductible</b>	<b>Family Deductible (3)</b>	<b>Single Deductible</b>	<b>Family Deductible (3)</b>
• 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
<b>Maximum Out-of-Pocket Expense Limit</b> (1), (2), (3)				
• Individual	\$0		\$6,000	
• Family	\$0		\$12,000	
<b>Lifetime Maximum Benefit</b>	\$2,000,000 per covered person			
<b>Preventive Care</b>				
• Routine annual physical exam (4)	<b>100%</b>		Not covered	
• Routine immunizations (to age 18) (4)				
• Routine Pap smears and PSA (4), (5)				
• Routine mammograms (5)				
• Routine lab, pathology and X-ray (4)	<b>100%</b> after deductible		Not covered	
<b>Physician Services</b>				
• Office visits (includes diagnostic lab and X-ray)	<b>100%</b> after deductible		<b>70%</b> after deductible	
• Allergy testing, injections and serum				
• Inpatient services				
• Outpatient services (includes surgery)				
<b>Hospital Services</b>				
• Inpatient care	<b>100%</b> after deductible		<b>70%</b> after deductible	
• Outpatient surgery – facility				
• Outpatient nonsurgical				
• Emergency room (including physician visits)				
<b>Other Medical Services</b>				
• Skilled nursing facility (up to 30 days per calendar year) (6)	<b>100%</b> after deductible		<b>70%</b> after deductible	
• Home healthcare (up to 60 visits per calendar year) (6)				
• Durable medical equipment (6)				
• Hospice (6), (7)				
• Complications of pregnancy and sick baby services				
• Transplant services (organ) (6)	<b>100%</b> after deductible (when services are performed at a National Transplant Network provider)		<b>70%</b> after deductible (limited to \$35,000 per covered transplant)	
<b>Prescription Drugs</b> (9)	Discount card included (This added value feature is not insurance.)		Not covered	
<b>Optional Benefits</b> (8)				
• Lifetime maximum benefit	\$5,000,000 per covered person			
• \$500 Supplemental Accident Benefit (Treatment must be provided within 90 days of the injury.)	First \$500 per accident at <b>100%</b> , then base plan benefits apply			
• \$1,000 Supplemental Accident Benefit (Treatment must be provided within 90 days of the injury.)	First \$1,000 per accident at <b>100%</b> , then base plan benefits apply			

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 non-network providers:
  - 50 percent of your payment toward the deductible is credited to the deductible for network 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) \$300 of covered expenses per person per calendar year, subject to applicable coinsurance.
- (5) Age and/or frequency limits apply.
- (6) Prior authorization required in order to be eligible for these benefits.
- (7) 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.
- (8) These benefits are optional and can be added to your plan for an additional cost. Optional benefits may not be available in all areas.

- (9) There is no coverage for retail and/or mail order prescription drugs unless stated in the policy.

**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.**

# 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 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 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. Termination of the policy will not prejudice an existing claim that commenced prior to date of termination.
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.
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 neuromuscular 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 except as stated in the policy.

# Notes

# Notes

# HumanaOne plans at a glance<sup>1</sup>

	In-Network Coinsurance		In-Network Plan Deductible		HSA-Qualified	Separate Prescription Deductible (copays apply)	In-Network Office Visit Copayment	Lifetime Maximum (per individual)
	Health Plan Pays (copays may apply)	You Pay	Single	Family				
<b>Portrait</b> Share 80 Plus Rx and Copay	80%	20%	\$1,000 or \$2,500	\$2,000 or \$5,000	N/A	\$500 (per individual)	unlimited	\$5 million
<b>Autograph</b> Total Plus Rx/HSA	100%	0%	\$1,500, \$2,500, \$3,500 or \$5,000	\$3,000, \$5,000, \$7,000 or \$10,000	✓	Rx applies to medical deductible	N/A	\$5 million
<b>Autograph</b> Total/HSA	100%	0%	\$2,000, \$3,000, \$4,000 or \$5,200	\$4,000, \$6,000, \$8,000 or \$10,400	✓	N/A	N/A	\$2 million
<b>Autograph</b> Share 80/HSA	80%	20%	\$2,000 or \$3,000	\$4,000 or \$6,000	✓	N/A	N/A	\$2 million
<b>Autograph</b> Share 80 Plus Rx and Copay	80%	20%	\$5,000 or \$6,000	\$10,000 or \$12,000	N/A	\$1,000 (per individual)	6 visits per year	\$5 million
<b>Autograph</b> Share 70 Plus Rx	70%	30%	\$2,500 or \$5,000	\$5,000 or \$10,000	N/A	\$1,000 (per individual)	N/A	\$2 million
<b>monogram</b> Total Plus Rx	100%	0%	\$7,500	\$15,000	N/A	\$1,000 (per individual)	N/A	\$2 million

<sup>1</sup> The above chart is not all-inclusive. Limitations, exclusions and waiting periods apply. For a list of covered benefits including out-of-network coverage please refer to page 3 & 4 of this booklet.

## Shape your plan with these optional benefits<sup>2</sup>:

- Decreased Prescription Deductible
- Supplemental Accident Benefit
- Term Life Insurance
- Increased Lifetime Maximum

<sup>2</sup> Optional benefits can vary by state and/or plan, and are available at an additional cost.

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, terms and conditions of the policy will govern. All applications are subject to approval. Waiting periods, limitations and exclusions apply.

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



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