

Portrait: Share 80 Plus Rx Unlimited



Nevada

		Plan pays for services from NETWORK providers	Plan pays for services from NON-NETWORK providers
Deductible options¹ • per calendar year • copayments do not apply	• individual	\$1,000 or \$2,500	\$2,000 or \$5,000
	• family (two family members must each meet their individual deductible)	\$2,000 or \$5,000	\$4,000 or \$10,000
Deductible carryover	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.		
Office visit copayment		\$35 primary care/\$50 specialist unlimited visits for illness or injury	Not applicable
Coinsurance out-of-pocket limit¹ • per calendar year • deductibles and copayments do not apply	• individual	\$2,000	\$8,000
	• family	\$4,000	\$16,000
Preventive care	• preventive office visits ^{2,3} • child immunizations to age 18 ^{2,3} • prostate screening ^{2,3}	80%	50% after deductible
	• Pap smear and mammogram • colorectal cancer screening	80%	60% after deductible
	• preventive lab and X-ray ^{2,3}	80% after deductible	50% after deductible
Physician services	• office visits (including allergy injections)	100% after office visit copayment	60% after deductible
	• diagnostic lab and X-ray ⁴ • allergy testing	First \$200 per calendar year 100% then 80% after deductible	60% after deductible
	• allergy serum • inpatient and outpatient services • surgery ⁵	80% after deductible	60% after deductible
Facility services	• inpatient and outpatient services • outpatient surgery ⁷	80% after deductible	60% after deductible
	• emergency services (copayment waived if admitted)	80% after \$75 copayment per visit and deductible	60% after \$75 copayment per visit and deductible
Rx4 prescription drug⁶ • medical out-of-pocket maximum does not apply	• deductible per individual • copay for each prescription or refill (up to 90-day supply; with applicable copay for each 30 day supply)	Separate \$500 deductible*	
		Level 1 \$15*	Level 2 \$35
		Level 3 \$55	Level 4 25%
	• copayment maximum (applies to Level 4 drugs only)	\$2,500 per individual per calendar year	
	• benefit per prescription or refill	100% after prescription copayment	70% after prescription copayment
	• mail order (up to 90-day supply)	100% after three times retail copay	70% after three times retail copay
Other medical services • prior authorization required in order to be eligible for the maximum benefits	• skilled nursing facility (up to 30 days per admission) • hospice ⁷ • home health care (up to 60 visits per calendar year) • durable medical equipment • pregnancy complications and sick baby services (no prior authorization required)	80% after deductible	60% after deductible
	• transplant services	80% after deductible when services are received from a Humana Transplant Network provider	60% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant
Lifetime maximum benefit	\$5,000,000 per covered person		
Basic mental health² • \$2,500 per calendar year • medical out-of-pocket maximum does not apply	• inpatient services • outpatient and office therapy sessions (outpatient services not to exceed \$500 of the total benefit)	50% after deductible	50% after deductible
Severe mental health	• inpatient services (up to 40 days per calendar year) • outpatient and office therapy sessions (up to 40 days per calendar year)	80% after deductible	60% after deductible
Chemical and alcohol dependency	• inpatient services (up to \$9,000 per calendar year) • outpatient and office therapy sessions (up to \$2,500 per calendar year) • treatment for withdrawal (up to \$1,500 per calendar year)	80% after deductible	60% after deductible

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Optional benefits <ul style="list-style-type: none">• 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">• prescription drug deductible• lifetime maximum• supplemental accident benefit (\$500 or \$1,000) (treatment must be provided within 90 days of the injury)	With this option no deductible is required before Rx benefits are payable Increase to \$8,000,000 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
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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
 - 50 percent of your out-of-pocket costs are credited to the out-of-pocket maximum for network providersOnce you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
2. **Benefit payable after 90-day waiting period for preventive care and 12 month waiting period for basic mental health.**
3. Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance.
4. MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
5. Outpatient benefits payable after 90-day waiting period for nonemergency removal of tonsils and/or adenoids, and after 180-day waiting period for nonemergency surgical treatment for bunions, varicose veins, hemorrhoids or hernia (does not apply to strangulated or incarcerated hernia).
6. 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.
7. 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.

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 judgement 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 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 19 years if the child is not a full-time student.

Pre-existing conditions

A pre-existing condition is a sickness or injury for which medical advice, diagnosis, care or treatment was recommended or received 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; 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 or dental anesthesia services for a dependent child under certain conditions), 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 which results in a conviction.
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. 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.
24. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
25. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
26. 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.
27. Any drug, medicine or device which is not FDA approved.
28. Contraceptives other than oral, including implant systems and devices regardless of the purpose for which prescribed.
29. Medications, drugs or hormones to stimulate growth.
30. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a noncovered injury or sickness.
31. 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.
32. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
33. Drugs used in treatment of nail fungus.
34. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
35. Vitamins, dietary products and any other nonprescription supplements.
36. Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of a severe mental disorder.



Insured by Humana Insurance Company or HumanaDental 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.