Short Term Medical 100/75

HUMANA *one*

Ohio

Humana*One* Short Term Medical plans: Right plan, right time

Humana*One*'s Short Term Medical plans can help protect you and your family if you find yourself without health insurance. You can choose the plan you need and have coverage for unexpected illness, injuries and accidents until you receive permanent coverage.

It's an ideal choice if you're:

- a student or recent graduate
- between jobs
- waiting for employer benefits to begin
- without coverage due to job or life changes
- a part-time, temporary or seasonal employee
- retired and waiting for Medicare eligibility

And the best part is that if you are eligible you can receive coverage as quickly as the day after applying. You don't have to wait weeks for the coverage you need today.

Humana*One* Short Term Medical plans offer:

- **Coverage you need:**

  All of Humana*One's* Short Term Medical plans include coverage for doctor office visits (for illness and injury), inpatient and outpatient procedures, emergency services, and prescription drugs.

- **Choice of deductibles:**

  We offer a range of deductibles on our Short Term Medical plans to ensure you get the coverage you need at a price you can afford.

- **Network Savings:**

  With these short term plans, you have access to a large network of doctors, whether you are at home or traveling. It's likely the physicians you currently use are already among our network providers. Keep in mind that you'll receive the most savings when visiting network providers, but you're still covered for most services if you choose to visit a non-network provider.

- **Service you can rely on:**

  You will be well-taken care of at Humana*One*. Every step of the way has been designed to provide you with a simple and hassle-free experience.

Membership in the Peoples' Benefit Alliance is required, at an additional cost, in order to be eligible to apply for this health plan.

This plan does not cover pre-existing conditions and is not renewable.
For additional plan details, including limitations and exclusions please review the following benefit summary.

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Ohio Short Term Medical 100/75 plan

This plan is available for a minimum of 30 days and a maximum of six months **Pre-existing conditions are not covered under this plan**		Plan pays for services from **NETWORK** providers	Plan pays for services from **NON-NETWORK** providers
Deductible options[1] • per benefit period	• individual	$1,000, $2,500 or $5,000	$2,000, $5,000 or $10,000
	• family (two family members must each meet their individual deductible)	$2,000, $5,000 or $10,000	$4,000, $10,000 or $20,000
Coinsurance out-of-pocket limit[1] • per benefit period • deductibles do not apply	• individual	Not applicable	$5,000
	• family	Not applicable	$10,000
Preventive care	• preventive office visits • child immunizations age 9 to 18 • prostate screening • preventive lab and X-ray	Not covered	Not covered
	• colorectal cancer screening (includes exam and lab tests) • Pap smear and mammogram • child health supervision services birth to age one (up to $500 per benefit period, includes $75 maximum for annual hearing screening) • child health supervision services age 1 through 8 (up to $150 per benefit period)	100% after deductible	75% after deductible
Physician services	• office visits (including allergy injections) • diagnostic lab and X-ray[2] • allergy testing • allergy serum • inpatient and outpatient services • surgery	100% after deductible	75% after deductible
Facility services	• inpatient and outpatient services • outpatient surgery • emergency services	100% after deductible	75% after deductible
Prescription drug[3] • mail order not available	• deductible per individual	Integrated with medical	Integrated with medical
	• benefit per prescription or refill	100% after deductible	75% after deductible
Other medical services • prior authorization required in order to be eligible for these benefits	• skilled nursing facility (up to 30 days per benefit period) • home health care (up to 40 visits per benefit period) • durable medical equipment • pregnancy complications and sick baby services (no prior authorization required)	100% after deductible	75% after deductible
	• hospice	Not covered	Not covered
	• transplant services	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
Lifetime maximum benefit		$2,000,000 per covered person	
Mental health, chemical dependency	• inpatient services • outpatient and office therapy sessions	Not covered	Not covered
Alcoholism and detoxification • up to $550 benefit period maximum • medical out-of-pocket maximum does not apply	• inpatient services • outpatient and office therapy services	50% after deductible	50% after deductible

To be covered, expenses must be medically necessary and specified as covered. Please see your policy/certificate for more information on medical necessity and other specific plan benefits.

1. When you obtain care from non-network providers:
   - your payment toward the deductible is NOT credited to the deductible for network providers
   - your out-of-pocket costs are NOT credited to the out-of-pocket maximum for network providers
2. MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
3. If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.

Payments

Network providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible or coinsurance. Plan benefits paid to non-network providers are based on maximum allowable fees, as defined in your policy/certificate.

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.

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Medical limitations and exclusions

This is an outline of the limitations and exclusions for the Humana*One* plan listed above. It is designed for convenient reference. Consult the policy/certificate for a complete list of limitations and exclusions. Your policy/certificate is not renewable.

Eligibility

The issue ages for Humana*One* individual Short Term Medical plans are 30 days to 64 years 11 months. 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

No benefits are payable for any pre-existing condition. A pre-existing condition is a sickness or bodily injury which was diagnosed or treated, or which produced signs or symptoms during the 5-year period before the covered person's effective date of coverage.

HIPAA eligibility

If you recently lost group coverage through your employer and you have a pre-existing medical condition, a short term plan may not be ideal for you. If you purchase a short term plan instead of electing COBRA, you'll become ineligible for other guarantee-issue plans that are available through your state.

Other expenses not covered

Unless stated otherwise no benefits are payable for expenses arising from:

1. Conditions which first manifested during a prior Short Term Medical policy or certificate issued by us.
2. Services for a condition for which claims were submitted under a prior Short Term Medical policy or certificate issued by us.
3. Services not medically necessary or which are experimental, investigational or for research purposes.
4. Services not authorized or prescribed by a healthcare practitioner or for which no charge is made.
5. 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/certificate.
6. Charges in excess of the maximum allowable fee or which exceed any benefit maximum.
7. Hospice services.
8. Expenses incurred before the effective date.
9. Expense incurred after the date coverage is terminated except as provided under the Extension of Benefits.
10. Cosmetic procedures and any related complications except as stated in the policy/certificate.
11. Custodial or maintenance care.
12. Preventive care services except as stated in the policy/certificate.
13. Any drug, medicine or device which is not FDA approved.
14. Contraceptives, including oral and transdermal, whether medication or device.
15. Medications, drugs or hormones to stimulate growth.
16. Legend drugs not recommended or deemed necessary by us or drugs prescribed for a non-covered bodily injury or sickness.
17. 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.
18. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
19. Drugs used in treatment of nail fungus
20. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than 1 year from the date of the original order.
21. Vitamins, dietary products and any other non-prescription supplements.
22. Infertility services.
23. Pregnancy and well-baby expenses.
24. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
25. Vision therapy; all types of refractive keratoplastics or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses, hearing aids; dental exams.
26. Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests except as stated in the policy/certificate.
27. Services received at an emergency room unless required because of emergency care.
28. Dental services (except for dental injury), appliances or supplies.
29. War or any act of war, whether declared or not, commission or attempt to commit a civil or criminal battery or felony.
30. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation except as stated in the policy/certificate.
31. Any treatment for the purpose of reducing obesity or any use of obesity reduction procedures to treat sickness or bodily injury caused by, complicated by or exacerbated by obesity, including but not limited to surgical procedures.
32. Nicotine habit or addiction; educational or vocational 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.
33. Foot care services.
34. Any treatment for mental health, including but not limited to prescription drugs except as stated in the policy/certificate.
35. Charges for non-medical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
36. 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.
37. Hair prosthesis; hair transplants or wigs.
38. Temporomanibular joint disorder, crainomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck.
39. Surgical treatment for hernia or removal of tonsils and/or adenoids unless the condition requires emergency care.
40. Surgical treatment for bunions, varicose veins or hemorrhoids.
41. Bodily injury and sickness arising out of the course of any occupation employment or activity for compensation profit or gain, whether or not benefits are available under Workers' Compensation.
42. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.
43. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
44. Charges covered by other medical payments insurance.
45. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
46. 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.

Extension of Benefits:

Extension of Benefit provision will apply (for no additional premium) with Short Term Medical plans under the following conditions:

1. You have met your deductible and are totally disabled—coverage for the disabling condition continues, but not beyond the earliest of the following dates: a) The date which you are no longer continuously confined in a hospital; b) the date you are no longer certified totally disabled; c) the date any maximum benefit or your individual lifetime maximum is met; d) the last day of a 12 month period following the expiration of your plan; e) the earliest day permitted by law.
2. You have met your deductible and are being treated for complications of, or need follow-up treatment for, a sickness that commenced or an injury sustained during the policy/certificate period: a) $1,000 maximum benefit provided for a period of not more than 60 days beyond the expiration date.

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Important information about Association plans:

The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Peoples' Benefit Alliance is required, at an additional cost, in order to be eligible to apply for this health plan.

Insured by Humana Insurance Company

Applications are subject to approval. Limitations and exclusions apply.

The Humana*One* 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/certificate 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/certificate will govern.

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Certificate number: OH-71013-01 1/2008

Ohio

Humana*One* Short Term Medical plans: Right plan, right time

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It's an ideal choice if you're:

- a student or recent graduate
- between jobs
- waiting for employer benefits to begin
- without coverage due to job or life changes
- a part-time, temporary or seasonal employee
- retired and waiting for Medicare eligibility

And the best part is that if you are eligible you can receive coverage as quickly as the day after applying. You don't have to wait weeks for the coverage you need today.

Humana*One* Short Term Medical plans offer:

- **Coverage you need:**

  All of Humana*One's* Short Term Medical plans include coverage for doctor office visits (for illness and injury), inpatient and outpatient procedures, emergency services, and prescription drugs.

- **Choice of deductibles:**

  We offer a range of deductibles on our Short Term Medical plans to ensure you get the coverage you need at a price you can afford.

- **Network Savings:**

  With these short term plans, you have access to a large network of doctors, whether you are at home or traveling. It's likely the physicians you currently use are already among our network providers. Keep in mind that you'll receive the most savings when visiting network providers, but you're still covered for most services if you choose to visit a non-network provider.

- **Service you can rely on:**

  You will be well-taken care of at Humana*One*. Every step of the way has been designed to provide you with a simple and hassle-free experience.

Membership in the Peoples' Benefit Alliance is required, at an additional cost, in order to be eligible to apply for this health plan.

This plan does not cover pre-existing conditions and is not renewable.
For additional plan details, including limitations and exclusions please review the following benefit summary.

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Ohio Short Term Medical 80/60 plan

This plan is available for a minimum of 30 days and a maximum of six months **Pre-existing conditions are not covered under this plan**		Plan pays for services from **NETWORK** providers	Plan pays for services from **NON-NETWORK** providers
Deductible options[1] • per benefit period	• individual	$500[2], $1,000, $2,500 or $5,000	$1,000, $2,000, $5,000 or $10,000
	• family (two family members must each meet their individual deductible)	$1,000, $2,000, $5,000 or $10,000	$2,000, $4,000, $10,000 or $20,000
Coinsurance out-of-pocket limit[1] • per benefit period • deductibles do not apply	• individual	$2,000	$8,000
	• family	$4,000	$16,000
Preventive care	• preventive office visits • child immunizations age 9 to 18 • prostate screening • preventive lab and X-ray	Not covered	Not covered
	• colorectal cancer screening (includes exam and lab tests) • Pap smear and mammogram • child health supervision services birth to age one (up to $500 per benefit period, includes $75 maximum for annual hearing screening) • child health supervision services age 1 through 8 (up to $150 per benefit period)	80% after deductible	60% after deductible
Physician services	• office visits (including allergy injections) • diagnostic lab and X-ray[3] • allergy testing • allergy serum • inpatient and outpatient services • surgery	80% after deductible	60% after deductible
Facility services	• inpatient and outpatient services • outpatient surgery • emergency services	80% after deductible	60% after deductible
Prescription drug[4] • mail order not available	• deductible per individual	Integrated with medical	Integrated with medical
	• benefit per prescription or refill	80% after deductible	60% after deductible
Other medical services • prior authorization required in order to be eligible for these benefits	• skilled nursing facility (up to 30 days per benefit period) • home health care (up to 40 visits per benefit period) • durable medical equipment • pregnancy complications and sick baby services (no prior authorization required)	80% after deductible	60% after deductible
	• hospice	Not covered	Not covered
	• 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		$2,000,000 per covered person	
Mental health, chemical dependency	• inpatient services • outpatient and office therapy sessions	Not covered	Not covered
Alcoholism and detoxification • up to $550 benefit period maximum • medical out-of-pocket maximum does not apply	• inpatient services • outpatient and office therapy services	50% after deductible	50% after deductible

To be covered, expenses must be medically necessary and specified as covered. Please see your policy/certificate for more information on medical necessity and other specific plan benefits.

1. When you obtain care from non-network providers:
   - your payment toward the deductible is NOT credited to the deductible for network providers
   - your out-of-pocket costs are NOT credited to the out-of-pocket maximum for network providers
2. Only available for plans six months or less in duration.
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.

Payments

Network providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible or coinsurance. Plan benefits paid to non-network providers are based on maximum allowable fees, as defined in your policy/certificate.

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.

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Medical limitations and exclusions

This is an outline of the limitations and exclusions for the Humana*One* plan listed above. It is designed for convenient reference. Consult the policy/certificate for a complete list of limitations and exclusions. Your policy/certificate is not renewable.

Eligibility

The issue ages for Humana*One* individual Short Term Medical plans are 30 days to 64 years 11 months. 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

No benefits are payable for any pre-existing condition. A pre-existing condition is a sickness or bodily injury which was diagnosed or treated, or which produced signs or symptoms during the 5-year period before the covered person's effective date of coverage.

HIPAA eligibility

If you recently lost group coverage through your employer and you have a pre-existing medical condition, a short term plan may not be ideal for you. If you purchase a short term plan instead of electing COBRA, you'll become ineligible for other guarantee-issue plans that are available through your state.

Other expenses not covered

Unless stated otherwise no benefits are payable for expenses arising from:

1. Conditions which first manifested during a prior Short Term Medical policy or certificate issued by us.
2. Services for a condition for which claims were submitted under a prior Short Term Medical policy or certificate issued by us.
3. Services not medically necessary or which are experimental, investigational or for research purposes.
4. Services not authorized or prescribed by a healthcare practitioner or for which no charge is made.
5. 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/certificate.
6. Charges in excess of the maximum allowable fee or which exceed any benefit maximum.
7. Hospice services.
8. Expenses incurred before the effective date.
9. Expense incurred after the date coverage is terminated except as provided under the Extension of Benefits.
10. Cosmetic procedures and any related complications except as stated in the policy/certificate.
11. Custodial or maintenance care.
12. Preventive care services except as stated in the policy/certificate.
13. Any drug, medicine or device which is not FDA approved.
14. Contraceptives, including oral and transdermal, whether medication or device.
15. Medications, drugs or hormones to stimulate growth.
16. Legend drugs not recommended or deemed necessary by us or drugs prescribed for a non-covered bodily injury or sickness.
17. 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.
18. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
19. Drugs used in treatment of nail fungus
20. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than 1 year from the date of the original order.
21. Vitamins, dietary products and any other non-prescription supplements.
22. Infertility services.
23. Pregnancy and well-baby expenses.
24. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
25. Vision therapy; all types of refractive keratoplastics or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses, hearing aids; dental exams.
26. Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests except as stated in the policy/certificate.
27. Services received at an emergency room unless required because of emergency care.
28. Dental services (except for dental injury), appliances or supplies.
29. War or any act of war, whether declared or not, commission or attempt to commit a civil or criminal battery or felony.
30. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation except as stated in the policy/certificate.
31. Any treatment for the purpose of reducing obesity or any use of obesity reduction procedures to treat sickness or bodily injury caused by, complicated by or exacerbated by obesity, including but not limited to surgical procedures.
32. Nicotine habit or addiction; educational or vocational 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.
33. Foot care services.
34. Any treatment for mental health, including but not limited to prescription drugs except as stated in the policy/certificate.
35. Charges for non-medical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
36. 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.
37. Hair prosthesis; hair transplants or wigs.
38. Temporomanibular joint disorder, crainomaxillary disorder, craniomandibular disorders and any treatment for jaw, joint or head and neck.
39. Surgical treatment for hernia or removal of tonsils and/or adenoids unless the condition requires emergency care.
40. Surgical treatment for bunions, varicose veins or hemorrhoids.
41. Bodily injury and sickness arising out of the course of any occupation employment or activity for compensation profit or gain, whether or not benefits are available under Workers' Compensation.
42. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.
43. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
44. Charges covered by other medical payments insurance.
45. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
46. 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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1. You have met your deductible and are totally disabled—coverage for the disabling condition continues, but not beyond the earliest of the following dates: a) The date which you are no longer continuously confined in a hospital; b) the date you are no longer certified totally disabled; c) the date any maximum benefit or your individual lifetime maximum is met; d) the last day of a 12 month period following the expiration of your plan; e) the earliest day permitted by law.
2. You have met your deductible and are being treated for complications of, or need follow-up treatment for, a sickness that commenced or an injury sustained during the policy/certificate period: a) $1,000 maximum benefit provided for a period of not more than 60 days beyond the expiration date.

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Insured by Humana Insurance Company

Applications are subject to approval. Limitations and exclusions apply.

The Humana*One* 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/certificate 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/certificate will govern.

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