Arizona

HumanaOne

Copay 70% plan

Membership in the Peoples' Benefit Alliance (PBA) is required, at an additional cost, in order to be eligible to apply for this health plan. The PBA is a not-for-profit membership organization that provides health, travel, consumer, and business-related discounts to its members.

About your plan

Who can apply for this plan – People between the ages of two weeks and sixty four and a half years of age can apply for Humana*One* health plans. A dependent child must be 25 years of age or younger.

Date the plan starts – If you've had major medical coverage in the last 63 days, your start date can be as early as the day you apply. If you haven't had coverage in the last 63 days, you'll have two start dates:
1. Subject to approval, your plan starts on the day you request, with coverage for preventive care and injuries caused by an accident
2. Unless Humana agrees to an earlier date, your start date for sickness begins on the 15th day after the approved effective date of your plan.

	In-network		Out-of-network	
Choose your medical deductible – The amount of covered expenses you'll pay out of your pocket before your plan begins to pay its share	Individual:	Family:	Individual:	Family:
Important to know: › Deductibles start over each new calendar year › Once three family members meet their individual deductibles, the family deductible will be met for all other family members	$ 1,500	$ 4,500	$ 3,000	$ 9,000
› For families with two people, only two individual deductibles need to be met	$ 2,500	$ 7,500	$ 5,000	$ 15,000
› This plan may include a separate deductible for certain conditions; see the deductible information on page 4 for details › The medical deductible is separate from other deductibles; expenses applied to the medical deductible won't apply to mental health, prescription drugs, or condition-specific deductibles	$ 5,000	$ 15,000	$ 10,000	$ 30,000
Coinsurance – The percentage of covered healthcare costs you have to pay while covered under this plan	You pay 30% of covered expenses after you pay your deductible		You pay 50% of covered expenses after you pay your deductible	
Your out-of-pocket coinsurance maximum – The amount you're required to pay toward the covered cost of your healthcare; premium, deductibles, access fees and copays don't apply	Individual: $ 5,000	Family: $ 10,000	Individual: $ 20,000	Family: $ 40,000
	Each covered persons coinsurance applies to meet this maximum			
Lifetime maximum – The total amount your plan will pay for covered expenses in your lifetime	❑ $3 million per covered person (included in plan) ❑ $5 million per covered person (increased maximum available for an extra cost)			

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

HUMANA one

Humana*One* Copay 70% plan

How your plan works

The details below give you a general idea of covered benefits for this plan. It doesn't explain everything. To be covered, expenses must be medically necessary and listed as covered in your Certificate. A certificate is a document which outlines the benefits, provisions, and limitations of your plan. Please refer to a Certificate for the actual terms and conditions of your plan. This plan also has things that are not covered or limited. You should know about these. See page 4 for details.

	In-network	Out-of-network
Preventive and other office visits **Important to know:** › Copays don't count toward your deductible or out-of-pocket coinsurance maximum	The plan pays 100% after you pay a copay per visit for the first three visits; then you pay 30% after you pay your deductible: • $35 for a primary care physician • $60 for a specialist • $60 for an urgent care visit	You pay 50% after you pay your deductible
Lab and X-rays – includes Pap smear, prostate screening, mammogram, and allergy testing **Important to know:** › Preventive Pap smear and preventive mammogram are not subject to in-network deductible and coinsurance	Plan pays $300 per calendar year at 100%. Then you pay 30% after you pay your deductible (MRI, CAT, EEG, EKG, ECG , cardiac catheterization, endoscopic services, and pulmonary function studies are not included in the first $300 of coverage. You pay 30% after you pay your deductible.)	You pay 50% after you pay your deductible
Inpatient hospital and outpatient services Note: doctors and hospitals often send separate bills	You pay 30% after you pay your deductible	You pay 50% after you pay your deductible
Emergency room **Important to know:** › If you're admitted, you don't pay the access fee	You pay a $125 access fee per visit; then you pay 30% after you pay your deductible	You pay a $125 access fee per visit; then you pay 30% after you pay your deductible
Ambulance	You pay 30% after you pay your deductible	You pay 30% after you pay your deductible
	The plan pays up to $15,000 per calendar year (this includes both in- and out-of-network services).	
Transplants	You pay 30% after you pay your deductible when you get services from a Humana Transplant Network provider	You pay 50% after you pay your deductible. Plan pays up to $35,000 per transplant
Mental health (mental illness and chemical dependency) – includes inpatient and outpatient services **Important to know:** › There is a 12-month waiting period before this plan pays benefits › The mental health deductible is separate from other deductibles; expenses applied to the mental health deductible won't apply to the other deductibles for your plan such as medical, prescription drugs, or certain illnesses	You first pay your mental health deductible, which is the same amount as your in-network medical deductible Then, you pay 50%	You first pay your mental health deductible, which is the same amount as your out-of-network medical deductible Then, you pay 50%
	The plan pays up to $2,500 per calendar year. (this includes both in- and out-of-network services). Outpatient services are limited to $500 per calendar year of the overall $2,500. Covered expenses for mental health don't apply to the medical out-of-pocket maximum.	
Other medical services **Important to know:** › Spinal manipulations, adjustments, and modalities performed by a Chiropractor apply to but are not limited by the 10 visit maximum	You pay 30% after you pay your deductible	You pay 50% after you pay your deductible
	These services are covered with the following combined in- and out-of-network limits: • Skilled nursing facility – up to 30 days per calendar year • Home health care • Hospice family counseling – up to 15 visits per family per lifetime • Hospice medical social services – up to $100 per family per lifetime • Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – combined, up to 30 visits per calendar year • Spinal manipulations, adjustments, and modalities – up to 10 visits per calendar year	

Your prescription drug coverage

	In-network	Out-of-network
Prescription drugs **Important to know:** › You pay the copay for each prescription or refill for each supply of medicine for 30 days › If you use an out-of-network pharmacy, you'll need to pay the full cost up front and then ask Humana to pay you back by submitting a claim › The prescription drug deductible is separate from other deductibles; expenses applied to the prescription drug deductible won't apply to the other deductibles for your plan such as medical, mental health, or certain illnesses › Prescription drug deductibles and copays do not apply to the medical out-of-pocket maximum › Find details about Humana's preferred mail-order service at **RightSourceRx.com**	**1. Your covered drug expenses are first applied to your drug deductible** (unless a level 1 drug – with these drugs you only have to pay your copay, no deductible) ❑ $1,000 deductible (included in plan) ❑ $500 deductible (this lower deductible is available for an extra cost)	
	2. Once you've met your deductible, then you pay a copay: • $15 / level 1: low-cost generic and brand-name drugs (These drugs are covered before meeting your deductible) • $40 / level 2: higher cost generic and brand-name drugs • $65 / level 3: high-cost, mostly brand-name drugs • 35% / level 4: some drugs you inject and other high-cost drugs ($5,000 out-of-pocket maximum per person per calendar year on level 4 drugs)	
	3. Then, your plan pays any remaining costs for in-network drugs	**Then, you pay** 30% of out-of-network drug costs

Add extra benefits to your medical plan

The following benefits are available to you at an extra cost.

Make your Humana*One* plan fit your needs even better. Extra benefits are an easy and affordable way to get the coverage you need. Plus, in most cases, there's no separate application or underwriting.

Dental

Protect your healthy smile with affordable, easy-to-use optional dental benefits from one of the nation's largest dental insurers. For a low monthly premium, you can use more than 130,000 network providers. And if you're approved for a medical plan, you're approved for dental benefits – just choose the type of coverage that meets your needs:

- ❑ **Traditional Plus** includes coverage for preventive, basic, and major services. You can go to network or non-network dentists, but you'll pay less when you choose dentists in the network.
- ❑ **Preventive Plus** covers the most common preventive and basic services. Discounts are available for major services and basic services the plan doesn't cover.

Term life

Humana*One* makes it easy to get peace of mind and help plan for a secure future for your family. You can apply for a health plan and term life insurance at the same time. If you are approved for your health plan, you will also be eligible for up to $150,000 term life coverage. Term life insurance gives protection for a certain time, during which premiums stay the same.

Supplemental accident

With this extra benefit, the plan pays a set amount per covered person for treatment of an accident, excluding prescription drugs, even before you've met the plan deductible. Treatment must take place within 90 days of the accident.

- ❑ **$1,000:** Plan pays first $1,000 per accident at 100%, then your plan benefits apply
- ❑ **$2,500:** Plan pays first $2,500 per accident at 100%, then your plan benefits apply

Deductible credit you can use next year

If you have covered medical expenses that apply to your deductible between Oct. 1 and Dec. 31, you can apply the covered expenses to your deductible for the next year. This makes it easier to meet your deductible the following year. Deductible carryover credit applies to the medical, mental health, and deductibles for certain illnesses, but does not apply to the prescription drug deductible.

Contact your agent for plan details or more information.

Insured by HumanaDental Insurance Company, Humana Insurance Company

Condition-specific deductibles (deductibles for certain illnesses)

This plan may include condition-specific deductibles, or CSDs, of $2,500, $5,000, or $7,500 in-network ($5,000, $10,000, or $15,000 out-of-network). CSDs allow you to get coverage for services that wouldn't be covered otherwise or would have a waiting period. The CSD applies to certain conditions listed in your Certificate. If you have any of these conditions before your coverage starts, you'll have coverage for these services – you just need to meet the separate deductible first. After you meet the CSD, your plan will pay for covered expenses related to the condition at 100% for the rest of the calendar year. Prescriptions used to treat the condition don't apply to the CSD.

Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Network providers aren't the agents, employees, or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana doesn't provide medical services. Humana doesn't endorse or control your healthcare providers' clinical judgment or treatment recommendations. Your Certificate explains your share of the cost for network and out-of-network providers. It may include a deductible, a set amount (copayment or access fee), and a percent of the cost (coinsurance).

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay is based on Humana's maximum allowable fee.
- The provider can "balance bill" you for charges greater than the maximum allowable fee. These charges don't apply to your out-of-pocket limit or deductible.

Pre-existing conditions

A pre-existing condition is a sickness or bodily injury for which, during the five-year period immediately prior to the covered person's effective date of coverage: 1) the covered person sought, received or was recommended medical advice, consultation, diagnosis, care or treatment; 2) prescription drugs were prescribed; 3) signs or symptoms were exhibited; or 4) diagnosis was possible. 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 enrollment form provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana*One* individual health plan listed above. It is designed for convenient reference. Consult the Certificate for a complete list of limitations and exclusions. Your Certificate is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the Certificate. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and billing exclusions

- Services incurred before the effective date, after the termination date, or when premium is past due
- Charges in excess of the maximum allowable fee
- Charges in excess of the lifetime maximum benefit or any other benefit maximum
- Services not authorized, furnished, or prescribed by a healthcare provider
- Services for which no charge is made
- Services provided by a family member or person who resides with the covered person
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary
- Services not medically necessary, except for routine preventive services as stated in the Certificate

Elective and cosmetic services

- Cosmetic services, or any related complication
- Elective medical or surgical procedures
- Hair prosthesis, hair transplants, or hair implants
- Prophylactic services

Immunizations

- Immunizations except as stated in the Certificate

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury), appliances, or supplies
- Foot care services
- Hearing care that is routine
- Vision examinations or testing, eyeglasses, or contact lenses

Pregnancy and sexuality services

- Pregnancy except for complications of pregnancy as defined in the Certificate. Complications of pregnancy does NOT mean: False labor, occasional spotting, rest prescribed during the period of pregnancy, morning sickness, conditions associated with the management of a difficult pregnancy, but which do not constitute a distinct complication of pregnancy, prolonged labor, cessation of labor, breech baby, fetal distress, edema, or complicated delivery.
- Lactation therapy
- Elective medical or surgical abortion except as stated in the Certificate
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- Sterilization, including tubal ligation and vasectomy, and reversal of sterilization
- Infertility services
- Sex change services and sexual dysfunction
- Services rendered in a premenstrual syndrome clinic

Obesity-related services

- Any treatment for obesity
- Surgical procedures for the removal of excess skin and/or fat due to weight loss

Illness/injury circumstances

- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated in the Certificate
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, influence of an illegal substance, being intoxicated, or engaging in an illegal occupation

Care in certain settings

- Private duty nursing
- Custodial or maintenance care
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected sickness or bodily injury

Hospital services

- Services received in an emergency room unless required because of emergency care
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted
- Hospital inpatient services when the covered person is in observation status or when stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health

Mental health services

- Court-ordered mental health services
- Services and supplies that are rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services
- Services and supplies that are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation
- Marriage counseling

Other payment available

- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law
- Charges for which any other insurance providing medical payments exists

Services not considered medical

- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner

Other

- Any expense incurred for services received outside of the United States while residing outside of the United States for more than six consecutive months in a year except as required by law for emergency care services
- Biliary lithotripsy
- Chemonucleolysis
- Charges for growth hormones
- Cranial banding, unless otherwise determined by us
- Educational or vocational training or therapy, services, and schools
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations
- Genetic testing, counseling, or services
- Hyperhydrosis surgery
- Immunotherapy for food allergy
- Light treatment for Seasonal Affective Disorder (S.A.D.)
- Living expenses, travel, transportation, except as expressly provided in the Certificate
- Prolotherapy
- Sensory integration therapy
- Services for care or treatment of non-covered procedures, or any related complication
- Alternative medicine including but not limited to holistic medicine, acupuncture, and naturopathy
- Services that are experimental, investigational, or for research purposes
- Sleep therapy
- Treatment for TMJ, CMJ, or any jaw joint problem
- Treatment of nicotine habit or addiction
- Any drug, medicine or device which is not FDA approved
- Medications, drugs or hormones to stimulate growth
- Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered injury or sickness
- 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
- Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription
- Drugs used in treatment of nail fungus
- Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order
- Vitamins, dietary products, and any other nonprescription supplements

Certain services and prescription drugs require preauthorization and notification/prior authorization before services are rendered. Please visit Humana.com/members/tools for a detailed list.

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.

This document contains a general summary of covered benefits, exclusions and limitations. Please refer to the 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 Certificate will govern.

Your premium won't go up during the first year the Certificate is in force, as long as you stay in the same area and keep the same benefits. After the first year, we have the right to raise premiums on your renewal date, or more frequently if you move out of the service area or change benefits.

HUMANA *one*®

AZ-52417-HO 4/10
Certificate number: AZ-70155-01 4/2010, et al.

Arizona

HumanaOne

Copay 80% plan

Membership in the Peoples' Benefit Alliance (PBA) is required, at an additional cost, in order to be eligible to apply for this health plan. The PBA is a not-for-profit membership organization that provides health, travel, consumer, and business-related discounts to its members.

About your plan

Who can apply for this plan – People between the ages of two weeks and sixty four and a half years of age can apply for Humana*One* health plans. A dependent child must be 25 years of age or younger.

Date the plan starts – If you've had major medical coverage in the last 63 days, your start date can be as early as the day you apply. If you haven't had coverage in the last 63 days, you'll have two start dates:
1. Subject to approval, your plan starts on the day you request, with coverage for preventive care and injuries caused by an accident
2. Unless Humana agrees to an earlier date, your start date for sickness begins on the 15th day after the approved effective date of your plan.

	In-network		Out-of-network	
Choose your medical deductible – The amount of covered expenses you'll pay out of your pocket before your plan begins to pay its share	Individual:	Family:	Individual:	Family:
Important to know: › Deductibles start over each new calendar year › Once three family members meet their individual deductibles, the family deductible will be met for all other family members › For families with two people, only two individual deductibles need to be met › This plan may include a separate deductible for certain conditions; see the deductible information on page 4 for details › The medical deductible is separate from other deductibles; expenses applied to the medical deductible won't apply to mental health, prescription drugs, or condition-specific deductibles	$ 3,500	$ 10,500	$ 7,000	$ 21,000
	$ 5,000	$ 15,000	$ 10,000	$ 30,000
Coinsurance – The percentage of covered healthcare costs you have to pay while covered under this plan	You pay 20% of covered expenses after you pay your deductible		You pay 40% of covered expenses after you pay your deductible	
Your out-of-pocket coinsurance maximum – The amount you're required to pay toward the covered cost of your healthcare; premium, deductibles, access fees and copays don't apply	Individual: $ 3,500	Family: $ 7,000	Individual: $ 12,000	Family: $ 24,000
	Each covered persons coinsurance applies to meet this maximum			
Lifetime maximum – The total amount your plan will pay for covered expenses in your lifetime	❑ $3 million per covered person (included in plan) ❑ $5 million per covered person (increased maximum available for an extra cost)			

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

HUMANA one

HumanaOne Copay 80% plan

How your plan works

The details below give you a general idea of covered benefits for this plan. It doesn't explain everything. To be covered, expenses must be medically necessary and listed as covered in your Certificate. A certificate is a document which outlines the benefits, provisions, and limitations of your plan. Please refer to a Certificate for the actual terms and conditions of your plan. This plan also has things that are not covered or limited. You should know about these. See page 4 for details.

	In-network	Out-of-network
Preventive and other office visits **Important to know:** › Copays don't count toward your deductible or out-of-pocket coinsurance maximum	The plan pays 100% after you pay a copay per visit for the first six visits; then you pay 20% after you pay your deductible: • $35 for a primary care physician • $60 for a specialist • $60 for an urgent care visit	You pay 40% after you pay your deductible
Lab and X-rays – includes Pap smear, prostate screening, mammogram, and allergy testing **Important to know:** › Preventive Pap smear and preventive mammogram are not subject to in-network deductible and coinsurance	Plan pays $400 per calendar year at 100%. Then you pay 20% after you pay your deductible (MRI, CAT, EEG, EKG, ECG , cardiac catheterization, endoscopic services, and pulmonary function studies are not included in the first $400 of coverage. You pay 20% after you pay your deductible.)	You pay 40% after you pay your deductible
Inpatient hospital and outpatient services Note: doctors and hospitals often send separate bills	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
Emergency room **Important to know:** › If you're admitted, you don't pay the access fee	You pay a $100 access fee per visit; then you pay 20% after you pay your deductible	You pay a $100 access fee per visit; then you pay 20% after you pay your deductible
Ambulance	You pay 20% after you pay your deductible	You pay 20% after you pay your deductible
	The plan pays up to $15,000 per calendar year (this includes both in- and out-of-network services).	
Transplants	You pay 20% after you pay your deductible when you get services from a Humana Transplant Network provider	You pay 40% after you pay your deductible. Plan pays up to $35,000 per transplant
Mental health (mental illness and chemical dependency) – includes inpatient and outpatient services **Important to know:** › There is a 12-month waiting period before this plan pays benefits › The mental health deductible is separate from other deductibles; expenses applied to the mental health deductible won't apply to the other deductibles for your plan such as medical, prescription drugs, or certain illnesses	You first pay your mental health deductible, which is the same amount as your in-network medical deductible Then, you pay 50%	You first pay your mental health deductible, which is the same amount as your out-of-network medical deductible Then, you pay 50%
	The plan pays up to $2,500 per calendar year. (this includes both in- and out-of-network services). Outpatient services are limited to $500 per calendar year of the overall $2,500. Covered expenses for mental health don't apply to the medical out-of-pocket maximum.	
Other medical services **Important to know:** › Spinal manipulations, adjustments, and modalities performed by a Chiropractor apply to but are not limited by the 10 visit maximum	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
	These services are covered with the following combined in- and out-of-network limits: • Skilled nursing facility – up to 30 days per calendar year • Home health care • Hospice family counseling – up to 15 visits per family per lifetime • Hospice medical social services – up to $100 per family per lifetime • Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – combined, up to 30 visits per calendar year • Spinal manipulations, adjustments, and modalities – up to 10 visits per calendar year	

Your prescription drug coverage

	In-network	Out-of-network
Prescription drugs **Important to know:** › You pay the copay for each prescription or refill for each supply of medicine for 30 days › If you use an out-of-network pharmacy, you'll need to pay the full cost up front and then ask Humana to pay you back by submitting a claim › The prescription drug deductible is separate from other deductibles; expenses applied to the prescription drug deductible won't apply to the other deductibles for your plan such as medical, mental health, or certain illnesses › Prescription drug deductibles and copays do not apply to the medical out-of-pocket maximum › Find details about Humana's preferred mail-order service at **RightSourceRx.com**	**1. Your covered drug expenses are first applied to your drug deductible** (unless a level 1 drug – with these drugs you only have to pay your copay, no deductible) ❑ $700 deductible (included in plan) ❑ $300 deductible (this lower deductible is available for an extra cost)	
	2. Once you've met your deductible, then you pay a copay: • $15 / level 1: low-cost generic and brand-name drugs (These drugs are covered before meeting your deductible) • $35 / level 2: higher cost generic and brand-name drugs • $60 / level 3: high-cost, mostly brand-name drugs • 35% / level 4: some drugs you inject and other high-cost drugs ($5,000 out-of-pocket maximum per person per calendar year on level 4 drugs)	
	3. Then, your plan pays any remaining costs for in-network drugs	**Then, you pay** 30% of out-of-network drug costs

Make your Humana*One* plan fit your needs even better. Extra benefits are an easy and affordable way to get the coverage you need. Plus, in most cases, there's no separate application or underwriting.

Add extra benefits to your medical plan

The following benefits are available to you at an extra cost.

Dental

Protect your healthy smile with affordable, easy-to-use optional dental benefits from one of the nation's largest dental insurers. For a low monthly premium, you can use more than 130,000 network providers. And if you're approved for a medical plan, you're approved for dental benefits – just choose the type of coverage that meets your needs:

- ❑ **Traditional Plus** includes coverage for preventive, basic, and major services. You can go to network or non-network dentists, but you'll pay less when you choose dentists in the network.
- ❑ **Preventive Plus** covers the most common preventive and basic services. Discounts are available for major services and basic services the plan doesn't cover.

Term life

Humana*One* makes it easy to get peace of mind and help plan for a secure future for your family. You can apply for a health plan and term life insurance at the same time. If you are approved for your health plan, you will also be eligible for up to $150,000 term life coverage. Term life insurance gives protection for a certain time, during which premiums stay the same.

Supplemental accident

With this extra benefit, the plan pays a set amount per covered person for treatment of an accident, excluding prescription drugs, even before you've met the plan deductible. Treatment must take place within 90 days of the accident.

- ❑ **$1,000:** Plan pays first $1,000 per accident at 100%, then your plan benefits apply
- ❑ **$2,500:** Plan pays first $2,500 per accident at 100%, then your plan benefits apply

Deductible credit you can use next year

If you have covered medical expenses that apply to your deductible between Oct. 1 and Dec. 31, you can apply the covered expenses to your deductible for the next year. This makes it easier to meet your deductible the following year. Deductible carryover credit applies to the medical, mental health, and deductibles for certain illnesses, but does not apply to the prescription drug deductible.

Contact your agent for plan details or more information.

Insured by HumanaDental Insurance Company, Humana Insurance Company

Condition-specific deductibles (deductibles for certain illnesses)

This plan may include condition-specific deductibles, or CSDs, of $2,500, $5,000, or $7,500 in-network ($5,000, $10,000, or $15,000 out-of-network). CSDs allow you to get coverage for services that wouldn't be covered otherwise or would have a waiting period. The CSD applies to certain conditions listed in your Certificate. If you have any of these conditions before your coverage starts, you'll have coverage for these services – you just need to meet the separate deductible first. After you meet the CSD, your plan will pay for covered expenses related to the condition at 100% for the rest of the calendar year. Prescriptions used to treat the condition don't apply to the CSD.

Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Network providers aren't the agents, employees, or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana doesn't provide medical services. Humana doesn't endorse or control your healthcare providers' clinical judgment or treatment recommendations. Your Certificate explains your share of the cost for network and out-of-network providers. It may include a deductible, a set amount (copayment or access fee), and a percent of the cost (coinsurance).

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay is based on Humana's maximum allowable fee.
- The provider can "balance bill" you for charges greater than the maximum allowable fee. These charges don't apply to your out-of-pocket limit or deductible.

Pre-existing conditions

A pre-existing condition is a sickness or bodily injury for which, during the five-year period immediately prior to the covered person's effective date of coverage: 1) the covered person sought, received or was recommended medical advice, consultation, diagnosis, care or treatment; 2) prescription drugs were prescribed; 3) signs or symptoms were exhibited; or 4) diagnosis was possible. 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 enrollment form provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana*One* individual health plan listed above. It is designed for convenient reference. Consult the Certificate for a complete list of limitations and exclusions. Your Certificate is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the Certificate. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and billing exclusions

- Services incurred before the effective date, after the termination date, or when premium is past due
- Charges in excess of the maximum allowable fee
- Charges in excess of the lifetime maximum benefit or any other benefit maximum
- Services not authorized, furnished, or prescribed by a healthcare provider
- Services for which no charge is made
- Services provided by a family member or person who resides with the covered person
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary
- Services not medically necessary, except for routine preventive services as stated in the Certificate

Elective and cosmetic services

- Cosmetic services, or any related complication
- Elective medical or surgical procedures
- Hair prosthesis, hair transplants, or hair implants
- Prophylactic services

Immunizations

- Immunizations except as stated in the Certificate

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury), appliances, or supplies
- Foot care services
- Hearing care that is routine
- Vision examinations or testing, eyeglasses, or contact lenses

Pregnancy and sexuality services

- Pregnancy except for complications of pregnancy as defined in the Certificate. Complications of pregnancy does NOT mean: False labor, occasional spotting, rest prescribed during the period of pregnancy, morning sickness, conditions associated with the management of a difficult pregnancy, but which do not constitute a distinct complication of pregnancy, prolonged labor, cessation of labor, breech baby, fetal distress, edema, or complicated delivery.
- Lactation therapy
- Elective medical or surgical abortion except as stated in the Certificate
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- Sterilization, including tubal ligation and vasectomy, and reversal of sterilization
- Infertility services
- Sex change services and sexual dysfunction
- Services rendered in a premenstrual syndrome clinic

Obesity-related services

- Any treatment for obesity
- Surgical procedures for the removal of excess skin and/or fat due to weight loss

Illness/injury circumstances

- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated in the Certificate
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, influence of an illegal substance, being intoxicated, or engaging in an illegal occupation

Care in certain settings

- Private duty nursing
- Custodial or maintenance care
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected sickness or bodily injury

Hospital services

- Services received in an emergency room unless required because of emergency care
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted
- Hospital inpatient services when the covered person is in observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health

Mental health services

- Court-ordered mental health services
- Services and supplies that are rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services
- Services and supplies that are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation
- Marriage counseling

Other payment available

- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law
- Charges for which any other insurance providing medical payments exists

Services not considered medical

- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner

Other

- Any expense incurred for services received outside of the United States while residing outside of the United States for more than six consecutive months in a year except as required by law for emergency care services
- Biliary lithotripsy
- Chemonucleolysis
- Charges for growth hormones
- Cranial banding, unless otherwise determined by us
- Educational or vocational training or therapy, services, and schools
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations
- Genetic testing, counseling, or services
- Hyperhydrosis surgery
- Immunotherapy for food allergy
- Light treatment for Seasonal Affective Disorder (S.A.D.)
- Living expenses, travel, transportation, except as expressly provided in the Certificate
- Prolotherapy
- Sensory integration therapy
- Services for care or treatment of non-covered procedures, or any related complication
- Alternative medicine including but not limited to holistic medicine, acupuncture, and naturopathy
- Services that are experimental, investigational, or for research purposes
- Sleep therapy
- Treatment for TMJ, CMJ, or any jaw joint problem
- Treatment of nicotine habit or addiction
- Any drug, medicine or device which is not FDA approved
- Medications, drugs or hormones to stimulate growth
- Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered injury or sickness
- 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
- Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription
- Drugs used in treatment of nail fungus
- Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order
- Vitamins, dietary products, and any other nonprescription supplements

Certain services and prescription drugs require preauthorization and notification/prior authorization before services are rendered. Please visit **Humana.com/members/tools** for a detailed list.

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.

This document contains a general summary of covered benefits, exclusions and limitations. Please refer to the 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 Certificate will govern.

Your premium won't go up during the first year the Certificate is in force, as long as you stay in the same area and keep the same benefits. After the first year, we have the right to raise premiums on your renewal date, or more frequently if you move out of the service area or change benefits.

HUMANA *one*®

AZ-52416-HO 4/10
Certificate number: AZ-70155-01 4/2010, et al.

Arizona

HumanaOne

Enhanced Copay 80% plan

Membership in the Peoples' Benefit Alliance (PBA) is required, at an additional cost, in order to be eligible to apply for this health plan. The PBA is a not-for-profit membership organization that provides health, travel, consumer, and business-related discounts to its members.

About your plan

Who can apply for this plan – People between the ages of two weeks and sixty four and a half years of age can apply for Humana*One* health plans. A dependent child must be 25 years of age or younger.

Date the plan starts – If you've had major medical coverage in the last 63 days, your start date can be as early as the day you apply. If you haven't had coverage in the last 63 days, you'll have two start dates:
1. Subject to approval, your plan starts on the day you request, with coverage for preventive care and injuries caused by an accident
2. Unless Humana agrees to an earlier date, your start date for sickness begins on the 15th day after the approved effective date of your plan.

	In-network		Out-of-network	
Choose your medical deductible – The amount of covered expenses you'll pay out of your pocket before your plan begins to pay its share	Individual:	Family:	Individual:	Family:
Important to know:	$ 500	$ 1,500	$ 1,000	$ 3,000
› Deductibles start over each new calendar year	$ 1,000	$ 3,000	$ 2,000	$ 6,000
› Once three family members meet their individual deductibles, the family deductible will be met for all other family members	$ 1,500	$ 4,500	$ 3,000	$ 9,000
› For families with two people, only two individual deductibles need to be met	$ 2,000	$ 6,000	$ 4,000	$ 12,000
› This plan may include a separate deductible for certain conditions; see the deductible information on page 4 for details	$ 2,500	$ 7,500	$ 5,000	$ 15,000
› The medical deductible is separate from other deductibles; expenses applied to the medical deductible won't apply to mental health, prescription drugs, or condition-specific deductibles	$ 3,500	$ 10,500	$ 7,000	$ 21,000
	$ 5,000	$ 15,000	$ 10,000	$ 30,000
Coinsurance – The percentage of covered healthcare costs you have to pay while covered under this plan	You pay 20% of covered expenses after you pay your deductible		You pay 40% of covered expenses after you pay your deductible	
Your out-of-pocket coinsurance maximum – The amount you're required to pay toward the covered cost of your healthcare; premium, deductibles, access fees and copays don't apply	Individual: $ 2,500	Family: $ 5,000	Individual: $ 10,000	Family: $ 20,000
	Each covered persons coinsurance applies to meet this maximum			
Lifetime maximum – The total amount your plan will pay for covered expenses in your lifetime	❑ $5 million per covered person (included in plan) ❑ $8 million per covered person (increased maximum available for an extra cost)			

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

AZ-52415-HO 4/10

HumanaOne Enhanced Copay 80% plan

How your plan works

The details below give you a general idea of covered benefits for this plan. It doesn't explain everything. To be covered, expenses must be medically necessary and listed as covered in your Certificate. A certificate is a document which outlines the benefits, provisions, and limitations of your plan. Please refer to a Certificate for the actual terms and conditions of your plan. This plan also has things that are not covered or limited. You should know about these. See page 4 for details.

	In-network	Out-of-network
Preventive and other office visits **Important to know:** › Copays don't count toward your deductible or out-of-pocket coinsurance maximum	The plan pays 100% after you pay a copay: • $35 for a primary care physician • $60 for a specialist • $60 for an urgent care visit	You pay 40% after you pay your deductible
Lab and X-rays – includes Pap smear, prostate screening, mammogram, and allergy testing **Important to know:** › Preventive Pap smear and preventive mammogram are not subject to in-network deductible and coinsurance	Plan pays $500 per calendar year at 100% per person. Then you pay 20% after you pay your deductible (MRI, CAT, EEG, EKG, ECG , cardiac catheterization, endoscopic services, and pulmonary function studies are not included in the first $500 of coverage. You pay 20% after you pay your deductible.)	You pay 40% after you pay your deductible
Inpatient hospital and outpatient services Note: doctors and hospitals often send separate bills	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
Emergency room **Important to know:** › If you're admitted, you don't pay the access fee	You pay a $100 access fee per visit; then you pay 20% after you pay your deductible	You pay a $100 access fee per visit; then you pay 20% after you pay your deductible
Ambulance	You pay 20% after you pay your deductible	You pay 20% after you pay your deductible
	The plan pays up to $15,000 per calendar year (this includes both in- and out-of-network services).	
Transplants	You pay 20% after you pay your deductible when you get services from a Humana Transplant Network provider	You pay 40% after you pay your deductible. Plan pays up to $35,000 per transplant
Mental health (mental illness and chemical dependency) – includes inpatient and outpatient services **Important to know:** › There is a 12-month waiting period before this plan pays benefits › The mental health deductible is separate from other deductibles; expenses applied to the mental health deductible won't apply to the other deductibles for your plan such as medical, prescription drugs, or certain illnesses	You first pay your separate mental health deductible, which is the same amount as your in-network medical deductible Then, you pay 50%	You first pay your mental health deductible, which is the same amount as your out-of-network medical deductible Then, you pay 50%
	The plan pays up to $2,500 per calendar year. (this includes both in- and out-of-network services). Outpatient services are limited to $500 per calendar year of the overall $2,500. Covered expenses for mental health don't apply to the medical out-of-pocket maximum.	
Other medical services **Important to know:** › Spinal manipulations, adjustments, and modalities performed by a Chiropractor apply to but are not limited by the 10 visit maximum	You pay 20% after you pay your deductible	You pay 40% after you pay your deductible
	These services are covered with the following combined in- and out-of-network limits: • Skilled nursing facility – up to 30 days per calendar year • Home health care • Hospice family counseling – up to 15 visits per family per lifetime • Hospice medical social services – up to $100 per family per lifetime • Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – combined, up to 30 visits per calendar year • Spinal manipulations, adjustments, and modalities – up to 10 visits per calendar year	

Your prescription drug coverage

	In-network	Out-of-network
Prescription drugs **Important to know:** › You pay the copay for each prescription or refill for each supply of medicine for 30 days › If you use an out-of-network pharmacy, you'll need to pay the full cost up front and then ask Humana to pay you back by submitting a claim › The prescription drug deductible is separate from other deductibles; expenses applied to the prescription drug deductible won't apply to the other deductibles for your plan such as medical, mental health, or certain illnesses › Prescription drug deductibles and copays do not apply to the medical out-of-pocket maximum › Find details about Humana's preferred mail-order service at **RightSourceRx.com**	**1. Your covered drug expenses are first applied to your drug deductible** (unless a level 1 drug – with these drugs you only have to pay your copay, no deductible) ❑ $500 deductible (included in plan) ❑ $150 deductible (this lower deductible is available for an extra cost)	
	2. Once you've met your deductible, then you pay a copay: • $15 / level 1: low-cost generic and brand-name drugs (These drugs are covered before meeting your deductible) • $35 / level 2: higher cost generic and brand-name drugs • $60 / level 3: high-cost, mostly brand-name drugs • 35% / level 4: some drugs you inject and other high-cost drugs ($5,000 out-of-pocket maximum per person per calendar year on level 4 drugs)	
	3. Then, your plan pays any remaining costs for in-network drugs	**Then, you pay** 30% of out-of-network drug costs

Add extra benefits to your medical plan

The following benefits are available to you at an extra cost.

Make your Humana*One* plan fit your needs even better. Extra benefits are an easy and affordable way to get the coverage you need. Plus, in most cases, there's no separate application or underwriting.

Dental

Protect your healthy smile with affordable, easy-to-use optional dental benefits from one of the nation's largest dental insurers. For a low monthly premium, you can use more than 130,000 network providers. And if you're approved for a medical plan, you're approved for dental benefits – just choose the type of coverage that meets your needs:

- ❑ **Traditional Plus** includes coverage for preventive, basic, and major services. You can go to network or non-network dentists, but you'll pay less when you choose dentists in the network.
- ❑ **Preventive Plus** covers the most common preventive and basic services. Discounts are available for major services and basic services the plan doesn't cover.

Term life

Humana*One* makes it easy to get peace of mind and help plan for a secure future for your family. You can apply for a health plan and term life insurance at the same time. If you are approved for your health plan, you will also be eligible for up to $150,000 term life coverage. Term life insurance gives protection for a certain time, during which premiums stay the same.

Supplemental accident

With this extra benefit, the plan pays a set amount per covered person for treatment of an accident, excluding prescription drugs, even before you've met the plan deductible. Treatment must take place within 90 days of the accident.

- ❑ **$1,000:** Plan pays first $1,000 per accident at 100%, then your plan benefits apply
- ❑ **$2,500:** Plan pays first $2,500 per accident at 100%, then your plan benefits apply

Deductible credit you can use next year

If you have covered medical expenses that apply to your deductible between Oct. 1 and Dec. 31, you can apply the covered expenses to your deductible for the next year. This makes it easier to meet your deductible the following year. Deductible carryover credit applies to the medical, mental health, and deductibles for certain illnesses, but does not apply to the prescription drug deductible.

Contact your agent for plan details or more information.

Insured by HumanaDental Insurance Company, Humana Insurance Company

Condition-specific deductibles (deductibles for certain illnesses)

This plan may include condition-specific deductibles, or CSDs, of $2,500, $5,000, or $7,500 in-network ($5,000, $10,000, or $15,000 out-of-network). CSDs allow you to get coverage for services that wouldn't be covered otherwise or would have a waiting period. The CSD applies to certain conditions listed in your Certificate. If you have any of these conditions before your coverage starts, you'll have coverage for these services – you just need to meet the separate deductible first. After you meet the CSD, your plan will pay for covered expenses related to the condition at 100% for the rest of the calendar year. Prescriptions used to treat the condition don't apply to the CSD.

Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Network providers aren't the agents, employees, or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana doesn't provide medical services. Humana doesn't endorse or control your healthcare providers' clinical judgment or treatment recommendations. Your Certificate explains your share of the cost for network and out-of-network providers. It may include a deductible, a set amount (copayment or access fee), and a percent of the cost (coinsurance).

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay is based on Humana's maximum allowable fee.
- The provider can "balance bill" you for charges greater than the maximum allowable fee. These charges don't apply to your out-of-pocket limit or deductible.

Pre-existing conditions

A pre-existing condition is a sickness or bodily injury for which, during the five-year period immediately prior to the covered person's effective date of coverage: 1) the covered person sought, received or was recommended medical advice, consultation, diagnosis, care or treatment; 2) prescription drugs were prescribed; 3) signs or symptoms were exhibited; or 4) diagnosis was possible. 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 enrollment form provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana*One* individual health plan listed above. It is designed for convenient reference. Consult the Certificate for a complete list of limitations and exclusions. Your Certificate is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the Certificate. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and billing exclusions

- Services incurred before the effective date, after the termination date, or when premium is past due
- Charges in excess of the maximum allowable fee
- Charges in excess of the lifetime maximum benefit or any other benefit maximum
- Services not authorized, furnished, or prescribed by a healthcare provider
- Services for which no charge is made
- Services provided by a family member or person who resides with the covered person
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary
- Services not medically necessary, except for routine preventive services as stated in the Certificate

Elective and cosmetic services

- Cosmetic services, or any related complication
- Elective medical or surgical procedures
- Hair prosthesis, hair transplants, or hair implants
- Prophylactic services

Immunizations

- Immunizations except as stated in the Certificate

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury), appliances, or supplies
- Foot care services
- Hearing care that is routine
- Vision examinations or testing, eyeglasses, or contact lenses

Pregnancy and sexuality services

- Pregnancy except for complications of pregnancy as defined in the Certificate. Complications of pregnancy does NOT mean: False labor, occasional spotting, rest prescribed during the period of pregnancy, morning sickness, conditions associated with the management of a difficult pregnancy, but which do not constitute a distinct complication of pregnancy, prolonged labor, cessation of labor, breech baby, fetal distress, edema, or complicated delivery.
- Lactation therapy
- Elective medical or surgical abortion except as stated in the Certificate
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- Sterilization, including tubal ligation and vasectomy, and reversal of sterilization
- Infertility services
- Sex change services and sexual dysfunction
- Services rendered in a premenstrual syndrome clinic

Obesity-related services

- Any treatment for obesity
- Surgical procedures for the removal of excess skin and/or fat due to weight loss

Illness/injury circumstances

- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated in the Certificate
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, influence of an illegal substance, being intoxicated, or engaging in an illegal occupation

Care in certain settings

- Private duty nursing
- Custodial or maintenance care
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected sickness or bodily injury

Hospital services

- Services received in an emergency room unless required because of emergency care
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted
- Hospital inpatient services when the covered person is in observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health

Mental health services

- Court-ordered mental health services
- Services and supplies that are rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services
- Services and supplies that are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation
- Marriage counseling

Other payment available

- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law
- Charges for which any other insurance providing medical payments exists

Services not considered medical

- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner

Other

- Any expense incurred for services received outside of the United States while residing outside of the United States for more than six consecutive months in a year except as required by law for emergency care services
- Biliary lithotripsy
- Chemonucleolysis
- Charges for growth hormones
- Cranial banding, unless otherwise determined by us
- Educational or vocational training or therapy, services, and schools
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations
- Genetic testing, counseling, or services
- Hyperhydrosis surgery
- Immunotherapy for food allergy
- Light treatment for Seasonal Affective Disorder (S.A.D.)
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- Services for care or treatment of non-covered procedures, or any related complication
- Alternative medicine including but not limited to holistic medicine, acupuncture, and naturopathy
- Services that are experimental, investigational, or for research purposes
- Sleep therapy
- Treatment for TMJ, CMJ, or any jaw joint problem
- Treatment of nicotine habit or addiction
- Any drug, medicine or device which is not FDA approved
- Medications, drugs or hormones to stimulate growth
- Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered injury or sickness
- 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
- Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription
- Drugs used in treatment of nail fungus
- Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order
- Vitamins, dietary products, and any other nonprescription supplements

Certain services and prescription drugs require preauthorization and notification/prior authorization before services are rendered. Please visit Humana.com/members/tools for a detailed list.

Important information about Association plans:
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This document contains a general summary of covered benefits, exclusions and limitations. Please refer to the 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 Certificate will govern.

Your premium won't go up during the first year the Certificate is in force, as long as you stay in the same area and keep the same benefits. After the first year, we have the right to raise premiums on your renewal date, or more frequently if you move out of the service area or change benefits.

HUMANA *one*®

AZ-52415-HO 4/10
Certificate number: AZ-70155-01 4/2010, et al.

Arizona

HumanaOne

Value 100% plan

Membership in the Peoples' Benefit Alliance (PBA) is required, at an additional cost, in order to be eligible to apply for this health plan. The PBA is a not-for-profit membership organization that provides health, travel, consumer, and business-related discounts to its members.

About your plan

Who can apply for this plan – People between the ages of two weeks and sixty four and a half years of age can apply for Humana*One* health plans. A dependent child must be 25 years of age or younger.

Date the plan starts – If you've had major medical coverage in the last 63 days, your start date can be as early as the day you apply. If you haven't had coverage in the last 63 days, you'll have two start dates:
1. Subject to approval, your plan starts on the day you request, with coverage for preventive care and injuries caused by an accident
2. Unless Humana agrees to an earlier date, your start date for sickness begins on the 15th day after the approved effective date of your plan.

	In-network		Out-of-network	
Choose your medical deductible – The amount of covered expenses you'll pay out of your pocket before your plan begins to pay its share	Individual:	Family:	Individual:	Family:
Important to know: › Deductibles start over each new calendar year › Once three family members meet their individual deductibles, the family deductible will be met for all other family members › For families with two people, only two individual deductibles need to be met › This plan may include a separate deductible for certain conditions; see the deductible information on page 4 for details › The medical deductible is separate from other deductibles; expenses applied to the medical deductible won't apply to mental health, prescription drugs, or condition-specific deductibles	$ 5,000	$ 15,000	$ 10,000	$ 30,000
	$ 7,500	$ 22,500	$ 15,000	$ 45,000
Coinsurance – The percentage of covered healthcare costs you have to pay while covered under this plan	Plan pays 100% of covered expenses after you pay your deductible		You pay 25% of covered expenses after you pay your deductible	
Your out-of-pocket coinsurance maximum – The amount you're required to pay toward the covered cost of your healthcare; premium, deductibles and access fees don't apply	Individual: $ 0	Family: $ 0	Individual: $ 5,000	Family: $ 10,000
	Each covered persons coinsurance applies to meet this maximum			
Lifetime maximum – The total amount your plan will pay for covered expenses in your lifetime	❑ $2 million per covered person (included in plan) ❑ $5 million per covered person (increased maximum available for an extra cost)			

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

HUMANA one

HumanaOne Value 100% plan

How your plan works

The details below give you a general idea of covered benefits for this plan. It doesn't explain everything. To be covered, expenses must be medically necessary and listed as covered in your Certificate. A certificate is a document which outlines the benefits, provisions, and limitations of your plan. Please refer to a Certificate for the actual terms and conditions of your plan. This plan also has things that are not covered or limited. You should know about these. See page 4 for details.

	In-network	Out-of-network
Preventive care – includes preventive: office visits, child immunizations (other than HPV and Meningococcal), Pap smear, and mammogram **Important to know:** › In-network preventive Pap smear and mammogram apply to but are not limited by the $500 maximum	The plan pays 100% up to a maximum of $500 per covered person per calendar year	You pay 25% after you pay your deductible
Office visits **Important to know:** › Does not include preventive office visits	The plan pays 100% after you pay your deductible for a primary care physician, specialist, or urgent care visit	You pay 25% after you pay your deductible
Lab and X-rays	Plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible
Inpatient hospital and outpatient services Note: doctors and hospitals often send separate bills	Plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible
Emergency room **Important to know:** › If you're admitted, you don't pay the access fee	You pay a $125 access fee per visit; then your plan pays 100% after you pay your deductible	You pay a $125 access fee per visit; then your plan pays 100% after you pay your deductible
Ambulance	Your plan pays 100% after you pay your deductible	Your plan pays 100% after you pay your deductible
	The plan pays up to $15,000 per calendar year (this includes both in- and out-of-network services).	
Transplants	Plan pays 100% after you pay your deductible when you get services from a Humana Transplant Network provider	You pay 25% after you pay your deductible. Plan pays up to $35,000 per transplant
Mental health (mental illness and chemical dependency) – includes inpatient and outpatient services **Important to know:** › There is a 12-month waiting period before this plan pays benefits › The mental health deductible is separate from other deductibles; expenses applied to the mental health deductible won't apply to the other deductibles for your plan such as medical, prescription drugs, or certain illnesses	You first pay your mental health deductible, which is the same amount as your in-network medical deductible Then, you pay 50%	You first pay your mental health deductible, which is the same amount as your out-of-network medical deductible Then, you pay 50%
	The plan pays up to $2,500 per calendar year. (this includes both in- and out-of-network services). Outpatient services are limited to $500 per calendar year of the overall $2,500. Covered expenses for mental health don't apply to the medical out-of-pocket maximum.	
Other medical services **Important to know:** › Spinal manipulations, adjustments, and modalities performed by a Chiropractor apply to but are not limited by the 10 visit maximum	Plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible
	These services are covered with the following combined in- and out-of-network limits: • Skilled nursing facility – up to 30 days per calendar year • Home health care • Hospice family counseling – up to 15 visits per family per lifetime • Hospice medical social services – up to $100 per family per lifetime • Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – combined, up to 30 visits per calendar year • Spinal manipulations, adjustments, and modalities – up to 10 visits per calendar year	

Your prescription drug coverage

	In-network	Out-of-network
Prescription drugs		
Important to know: › You pay the copay for each prescription or refill for each supply of medicine for 30 days › If you use an out-of-network pharmacy, you'll need to pay the full cost up front and then ask Humana to pay you back by submitting a claim › The prescription drug deductible is separate from other deductibles; expenses applied to the prescription drug deductible won't apply to the other deductibles for your plan such as medical, mental health, or certain illnesses › Prescription drug deductibles and copays do not apply to the medical out-of-pocket maximum › Find details about Humana's preferred mail-order service at **RightSourceRx.com**		
1. Your covered drug expenses are first applied to your drug deductible (unless a level 1 drug – with these drugs you only have to pay your copay, no deductible) ❑ $1,000 deductible (included in plan)		
2. Once you've met your deductible, then you pay a copay: • $15 / level 1: low-cost generic and brand-name drugs (These drugs are covered before meeting your deductible) • $40 / level 2: higher cost generic and brand-name drugs • $65 / level 3: high-cost, mostly brand-name drugs • 35% / level 4: some drugs you inject and other high-cost drugs ($5,000 out-of-pocket maximum per person per calendar year on level 4 drugs)		
3. Then, your plan pays any remaining costs for in-network drugs		**Then, you pay** 30% of out-of-network drug costs

Add extra benefits to your medical plan

The following benefits are available to you at an extra cost.

Make your Humana*One* plan fit your needs even better. Extra benefits are an easy and affordable way to get the coverage you need. Plus, in most cases, there's no separate application or underwriting.

Dental

Protect your healthy smile with affordable, easy-to-use optional dental benefits from one of the nation's largest dental insurers. For a low monthly premium, you can use more than 130,000 network providers. And if you're approved for a medical plan, you're approved for dental benefits – just choose the type of coverage that meets your needs:

- ❑ **Traditional Plus** includes coverage for preventive, basic, and major services. You can go to network or non-network dentists, but you'll pay less when you choose dentists in the network.
- ❑ **Preventive Plus** covers the most common preventive and basic services. Discounts are available for major services and basic services the plan doesn't cover.

Term life

Humana*One* makes it easy to get peace of mind and help plan for a secure future for your family. You can apply for a health plan and term life insurance at the same time. If you are approved for your health plan, you will also be eligible for up to $150,000 term life coverage. Term life insurance gives protection for a certain time, during which premiums stay the same.

Supplemental accident

With this extra benefit, the plan pays a set amount per covered person for treatment of an accident, excluding prescription drugs, even before you've met the plan deductible. Treatment must take place within 90 days of the accident.

- ❑ **$1,000:** Plan pays first $1,000 per accident at 100%, then your plan benefits apply
- ❑ **$2,500:** Plan pays first $2,500 per accident at 100%, then your plan benefits apply

Deductible credit you can use next year

If you have covered medical expenses that apply to your deductible between Oct. 1 and Dec. 31, you can apply the covered expenses to your deductible for the next year. This makes it easier to meet your deductible the following year. Deductible carryover credit applies to the medical, mental health, and deductibles for certain illnesses, but does not apply to the prescription drug deductible.

Contact your agent for plan details or more information.

Insured by HumanaDental Insurance Company, Humana Insurance Company

Condition-specific deductibles (deductibles for certain illnesses)

This plan may include condition-specific deductibles, or CSDs, of $2,500, $5,000, or $7,500 in-network ($5,000, $10,000, or $15,000 out-of-network). CSDs allow you to get coverage for services that wouldn't be covered otherwise or would have a waiting period. The CSD applies to certain conditions listed in your Certificate. If you have any of these conditions before your coverage starts, you'll have coverage for these services – you just need to meet the separate deductible first. After you meet the CSD, your plan will pay for covered expenses related to the condition at 100% for the rest of the calendar year. Prescriptions used to treat the condition don't apply to the CSD.

Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Network providers aren't the agents, employees, or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana doesn't provide medical services. Humana doesn't endorse or control your healthcare providers' clinical judgment or treatment recommendations. Your Certificate explains your share of the cost for network and out-of-network providers. It may include a deductible, a set amount (copayment or access fee), and a percent of the cost (coinsurance).

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay is based on Humana's maximum allowable fee.
- The provider can "balance bill" you for charges greater than the maximum allowable fee. These charges don't apply to your out-of-pocket limit or deductible.

Pre-existing conditions

A pre-existing condition is a sickness or bodily injury for which, during the five-year period immediately prior to the covered person's effective date of coverage: 1) the covered person sought, received or was recommended medical advice, consultation, diagnosis, care or treatment; 2) prescription drugs were prescribed; 3) signs or symptoms were exhibited; or 4) diagnosis was possible. 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 enrollment form provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana*One* individual health plan listed above. It is designed for convenient reference. Consult the Certificate for a complete list of limitations and exclusions. Your Certificate is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the Certificate. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and billing exclusions

- Services incurred before the effective date, after the termination date, or when premium is past due
- Charges in excess of the maximum allowable fee
- Charges in excess of the lifetime maximum benefit or any other benefit maximum
- Services not authorized, furnished, or prescribed by a healthcare provider
- Services for which no charge is made
- Services provided by a family member or person who resides with the covered person
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary
- Services not medically necessary, except for routine preventive services as stated in the Certificate

Elective and cosmetic services

- Cosmetic services, or any related complication
- Elective medical or surgical procedures
- Hair prosthesis, hair transplants, or hair implants
- Prophylactic services

Immunizations

- Immunizations except as stated in the Certificate

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury), appliances, or supplies
- Foot care services
- Hearing care that is routine
- Vision examinations or testing, eyeglasses, or contact lenses

Pregnancy and sexuality services

- Pregnancy except for complications of pregnancy as defined in the Certificate. Complications of pregnancy does NOT mean: False labor, occasional spotting, rest prescribed during the period of pregnancy, morning sickness, conditions associated with the management of a difficult pregnancy, but which do not constitute a distinct complication of pregnancy, prolonged labor, cessation of labor, breech baby, fetal distress, edema, or complicated delivery.
- Lactation therapy
- Elective medical or surgical abortion except as stated in the Certificate
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- Sterilization, including tubal ligation and vasectomy, and reversal of sterilization
- Infertility services
- Sex change services and sexual dysfunction
- Services rendered in a premenstrual syndrome clinic

Obesity-related services

- Any treatment for obesity
- Surgical procedures for the removal of excess skin and/or fat due to weight loss

Illness/injury circumstances

- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated in the Certificate
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, influence of an illegal substance, being intoxicated, or engaging in an illegal occupation

Care in certain settings

- Private duty nursing
- Custodial or maintenance care
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected sickness or bodily injury

Hospital services

- Services received in an emergency room unless required because of emergency care
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted
- Hospital inpatient services when the covered person is in observation status or when stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health

Mental health services

- Court-ordered mental health services
- Services and supplies that are rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services
- Services and supplies that are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation
- Marriage counseling

Other payment available

- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law
- Charges for which any other insurance providing medical payments exists

Services not considered medical

- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner

Other

- Any expense incurred for services received outside of the United States while residing outside of the United States for more than six consecutive months in a year except as required by law for emergency care services
- Biliary lithotripsy
- Chemonucleolysis
- Charges for growth hormones
- Cranial banding, unless otherwise determined by us
- Educational or vocational training or therapy, services, and schools
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations
- Genetic testing, counseling, or services
- Hyperhydrosis surgery
- Immunotherapy for food allergy
- Light treatment for Seasonal Affective Disorder (S.A.D.)
- Living expenses, travel, transportation, except as expressly provided in the Certificate
- Prolotherapy
- Sensory integration therapy
- Services for care or treatment of non-covered procedures, or any related complication
- Alternative medicine including but not limited to holistic medicine, acupuncture, and naturopathy
- Services that are experimental, investigational, or for research purposes
- Sleep therapy
- Treatment for TMJ, CMJ, or any jaw joint problem
- Treatment of nicotine habit or addiction
- Any drug, medicine or device which is not FDA approved
- Medications, drugs or hormones to stimulate growth
- Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered injury or sickness
- 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
- Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription
- Drugs used in treatment of nail fungus
- Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order
- Vitamins, dietary products, and any other nonprescription supplements

Certain services and prescription drugs require preauthorization and notification/prior authorization before services are rendered. Please visit Humana.com/members/tools for a detailed list.

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.

This document contains a general summary of covered benefits, exclusions and limitations. Please refer to the 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 Certificate will govern.

Your premium won't go up during the first year the Certificate is in force, as long as you stay in the same area and keep the same benefits. After the first year, we have the right to raise premiums on your renewal date, or more frequently if you move out of the service area or change benefits.

HUMANA *one*®

AZ-52418-HO 4/10
Certificate number: AZ-70155-01 4/2010, et al.

Arizona

HumanaOne

HSA 100% plan

Membership in the Peoples' Benefit Alliance (PBA) is required, at an additional cost, in order to be eligible to apply for this health plan. The PBA is a not-for-profit membership organization that provides health, travel, consumer, and business-related discounts to its members.

About your plan

Who can apply for this plan – People between the ages of two weeks and sixty four and a half years of age can apply for Humana*One* health plans. A dependent child must be 25 years of age or younger.

Date the plan starts – If you've had major medical coverage in the last 63 days, your start date can be as early as the day you apply. If you haven't had coverage in the last 63 days, you'll have two start dates:
1. Subject to approval, your plan starts on the day you request, with coverage for preventive care and injuries caused by an accident
2. Unless Humana agrees to an earlier date, your start date for sickness begins on the 15th day after the approved effective date of your plan.

	In-network		Out-of-network	
Choose your medical deductible – The amount of covered expenses you'll pay out of your pocket before your plan begins to pay its share	Individual:	Family:	Individual:	Family:
	$ 1,500	$ 3,000	$ 3,000	$ 6,000
	$ 2,500	$ 5,000	$ 5,000	$ 10,000
	$ 3,500	$ 7,000	$ 7,000	$ 14,000
	$ 5,000	$ 10,000	$ 10,000	$ 20,000
	$ 5,950	$ 11,900	$ 11,900	$ 23,800
Coinsurance – The percentage of covered healthcare costs you have to pay while covered under this plan	Plan pays 100% of covered expenses after you pay your deductible		You pay 30% of covered expenses after you pay your deductible	
Your out-of-pocket coinsurance maximum – The amount you're required to pay toward the covered cost of your healthcare; premium and deductibles don't apply	Individual: $ 0	Family: $ 0	Individual: $ 7,500	Family: $ 15,000
	Each covered persons coinsurance applies to meet this maximum			
Lifetime maximum – The total amount your plan will pay for covered expenses in your lifetime	❑ $2 million per covered person (included in plan) ❑ $5 million per covered person (increased maximum available for an extra cost)			

Important to know:
- Deductibles start over each new calendar year
- Benefits will be paid once the family deductible is met, regardless of the number of members on the plan
- This plan may include a separate deductible for certain conditions; see the deductible information on page 4 for details
- The medical deductible is separate from other deductibles; expenses applied to the medical deductible won't apply to mental health, prescription drugs, or condition-specific deductibles

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

HUMANA one

Humana*One* HSA 100% plan

How your plan works

The details below give you a general idea of covered benefits for this plan. It doesn't explain everything. To be covered, expenses must be medically necessary and listed as covered in your Certificate. A certificate is a document which outlines the benefits, provisions, and limitations of your plan. Please refer to a Certificate for the actual terms and conditions of your plan. This plan also has things that are not covered or limited. You should know about these. See page 4 for details.

	In-network	Out-of-network
Preventive and other office visits	The plan pays 100% after you pay your deductible for a primary care physician, specialist, or urgent care visit	You pay 30% after you pay your deductible
Lab and X-rays **Important to know:** › Preventive Pap smear and preventive mammogram are not subject to in-network deductible and coinsurance	Plan pays 100% after you pay your deductible	You pay 30% after you pay your deductible
Inpatient hospital and outpatient services Note: doctors and hospitals often send separate bills	Plan pays 100% after you pay your deductible	You pay 30% after you pay your deductible
Emergency room	Plan pays 100% after you pay your deductible	Plan pays 100% after you pay your deductible
Ambulance	Plan pays 100% after you pay your deductible	Plan pays 100% after you pay your deductible
	The plan pays up to $15,000 per calendar year (this includes both in- and out-of-network services).	
Transplants	Plan pays 100% after you pay your deductible when you get services from a Humana Transplant Network provider	You pay 30% after you pay your deductible. Plan pays up to $35,000 per transplant
Mental health (mental illness and chemical dependency) – includes inpatient and outpatient services	Not covered	Not covered
Other medical services **Important to know:** › Spinal manipulations, adjustments, and modalities performed by a Chiropractor apply to but are not limited by the 10 visit maximum	Plan pays 100% after you pay your deductible	You pay 30% after you pay your deductible
	These services are covered with the following combined in- and out-of-network limits: • Skilled nursing facility – up to 30 days per calendar year • Home health care • Hospice family counseling – up to 15 visits per family per lifetime • Hospice medical social services – up to $100 per family per lifetime • Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – combined, up to 30 visits per calendar year • Spinal manipulations, adjustments, and modalities – up to 10 visits per calendar year	

Your prescription drug coverage

	In-network	Out-of-network
Prescription drugs	Discount card only	Not covered
Important to know: › Find details about Humana's preferred mail-order service at **RightSourceRx.com**	This value-added feature is not insurance. There is no coverage for retail and/or mail order prescription drugs unless stated in the Certificate.	

Make your Humana*One* plan fit your needs even better. Extra benefits are an easy and affordable way to get the coverage you need. Plus, in most cases, there's no separate application or underwriting.

Add extra benefits to your medical plan

The following benefits are available to you at an extra cost.

Dental

Protect your healthy smile with affordable, easy-to-use optional dental benefits from one of the nation's largest dental insurers. For a low monthly premium, you can use more than 130,000 network providers. And if you're approved for a medical plan, you're approved for dental benefits – just choose the type of coverage that meets your needs:

- ❑ **Traditional Plus** includes coverage for preventive, basic, and major services. You can go to network or non-network dentists, but you'll pay less when you choose dentists in the network.
- ❑ **Preventive Plus** covers the most common preventive and basic services. Discounts are available for major services and basic services the plan doesn't cover.

Term life

Humana*One* makes it easy to get peace of mind and help plan for a secure future for your family. You can apply for a health plan and term life insurance at the same time. If you are approved for your health plan, you will also be eligible for up to $150,000 term life coverage. Term life insurance gives protection for a certain time, during which premiums stay the same.

Supplemental accident

With this extra benefit, the plan pays a set amount per covered person for treatment of an accident, excluding prescription drugs, even before you've met the plan deductible. Treatment must take place within 90 days of the accident.

- ❑ **$1,000:** Plan pays first $1,000 per accident at 100%, then your plan benefits apply
- ❑ **$2,500:** Plan pays first $2,500 per accident at 100%, then your plan benefits apply

Contact your agent for plan details or more information.

Insured by HumanaDental Insurance Company, Humana Insurance Company

Condition-specific deductibles (deductibles for certain illnesses)

This plan may include condition-specific deductibles, or CSDs, of $2,500, $5,000, or $7,500 in-network ($5,000, $10,000, or $15,000 out-of-network). CSDs allow you to get coverage for services that wouldn't be covered otherwise or would have a waiting period. The CSD applies to certain conditions listed in your Certificate. If you have any of these conditions before your coverage starts, you'll have coverage for these services – you just need to meet the separate deductible first. After you meet the CSD, your plan will pay for covered expenses related to the condition at 100% for the rest of the calendar year. Prescriptions used to treat the condition don't apply to the CSD.

Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Network providers aren't the agents, employees, or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana doesn't provide medical services. Humana doesn't endorse or control your healthcare providers' clinical judgment or treatment recommendations. Your Certificate explains your share of the cost for network and out-of-network providers. It may include a deductible, a set amount (copayment or access fee), and a percent of the cost (coinsurance).

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay is based on Humana's maximum allowable fee.
- The provider can "balance bill" you for charges greater than the maximum allowable fee. These charges don't apply to your out-of-pocket limit or deductible.

Pre-existing conditions

A pre-existing condition is a sickness or bodily injury for which, during the five-year period immediately prior to the covered person's effective date of coverage: 1) the covered person sought, received or was recommended medical advice, consultation, diagnosis, care or treatment; 2) prescription drugs were prescribed; 3) signs or symptoms were exhibited; or 4) diagnosis was possible. 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 enrollment form provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana*One* individual health plan listed above. It is designed for convenient reference. Consult the Certificate for a complete list of limitations and exclusions. Your Certificate is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the Certificate. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and billing exclusions

- Services incurred before the effective date, after the termination date, or when premium is past due
- Charges in excess of the maximum allowable fee
- Charges in excess of the lifetime maximum benefit or any other benefit maximum
- Services not authorized, furnished, or prescribed by a healthcare provider
- Services for which no charge is made
- Services provided by a family member or person who resides with the covered person
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary
- Services not medically necessary, except for routine preventive services as stated in the Certificate

Elective and cosmetic services

- Cosmetic services, or any related complication
- Elective medical or surgical procedures
- Hair prosthesis, hair transplants, or hair implants
- Prophylactic services

Immunizations

- Immunizations except as stated in the Certificate

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury), appliances, or supplies
- Foot care services
- Hearing care that is routine
- Vision examinations or testing, eyeglasses, or contact lenses

Pregnancy and sexuality services

- Pregnancy except for complications of pregnancy as defined in the Certificate. Complications of pregnancy does NOT mean: False labor, occasional spotting, rest prescribed during the period of pregnancy, morning sickness, conditions associated with the management of a difficult pregnancy, but which do not constitute a distinct complication of pregnancy, prolonged labor, cessation of labor, breech baby, fetal distress, edema, or complicated delivery.
- Lactation therapy
- Elective medical or surgical abortion except as stated in the Certificate
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- Sterilization, including tubal ligation and vasectomy, and reversal of sterilization
- Infertility services
- Sex change services and sexual dysfunction
- Services rendered in a premenstrual syndrome clinic

Obesity-related services

- Any treatment for obesity
- Surgical procedures for the removal of excess skin and/or fat due to weight loss

Illness/injury circumstances

- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated in the Certificate
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, influence of an illegal substance, being intoxicated, or engaging in an illegal occupation

Care in certain settings

- Private duty nursing
- Custodial or maintenance care
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected sickness or bodily injury

Hospital services

- Services received in an emergency room unless required because of emergency care
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted
- Hospital inpatient services when the covered person is in observation status or when stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health

Mental health services

- Court-ordered mental health services
- Marriage counseling
- Mental health including mental disorders, alcohol and chemical dependency

Other payment available

- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law
- Charges for which any other insurance providing medical payments exists

Services not considered medical

- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner

Other

- Any expense incurred for services received outside of the United States while residing outside of the United States for more than six consecutive months in a year except as required by law for emergency care services
- Biliary lithotripsy
- Chemonucleolysis
- Charges for growth hormones
- Cranial banding, unless otherwise determined by us
- Educational or vocational training or therapy, services, and schools
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations
- Genetic testing, counseling, or services
- Hyperhydrosis surgery
- Immunotherapy for food allergy
- Light treatment for Seasonal Affective Disorder (S.A.D.)
- Living expenses, travel, transportation, except as expressly provided in the Certificate
- Prolotherapy
- Sensory integration therapy
- Services for care or treatment of non-covered procedures, or any related complication
- Alternative medicine including but not limited to holistic medicine, acupuncture, and naturopathy
- Services that are experimental, investigational, or for research purposes
- Sleep therapy
- Treatment for TMJ, CMJ, or any jaw joint problem
- Treatment of nicotine habit or addiction
- Spinal manipulations, adjustments, and modalities
- 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 , unless otherwise stated in this Certificate

Certain services and prescription drugs require preauthorization and notification/prior authorization before services are rendered. Please visit Humana.com/members/tools for a detailed list.

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.

This document contains a general summary of covered benefits, exclusions and limitations. Please refer to the 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 Certificate will govern.

Your premium won't go up during the first year the Certificate is in force, as long as you stay in the same area and keep the same benefits. After the first year, we have the right to raise premiums on your renewal date, or more frequently if you move out of the service area or change benefits.

HUMANA *one*®

AZ-52420-HO 4/10
Certificate number: AZ-70155-01 4/2010, et al.

Arizona

HumanaOne

Enhanced HSA 100% plan

Membership in the Peoples' Benefit Alliance (PBA) is required, at an additional cost, in order to be eligible to apply for this health plan. The PBA is a not-for-profit membership organization that provides health, travel, consumer, and business-related discounts to its members.

About your plan

Who can apply for this plan – People between the ages of two weeks and sixty four and a half years of age can apply for Humana*One* health plans. A dependent child must be 25 years of age or younger.

Date the plan starts – If you've had major medical coverage in the last 63 days, your start date can be as early as the day you apply. If you haven't had coverage in the last 63 days, you'll have two start dates:
1. Subject to approval, your plan starts on the day you request, with coverage for preventive care and injuries caused by an accident
2. Unless Humana agrees to an earlier date, your start date for sickness begins on the 15th day after the approved effective date of your plan.

	In-network		Out-of-network	
Choose your medical deductible – The amount of covered expenses you'll pay out of your pocket before your plan begins to pay its share	Individual:	Family:	Individual:	Family:
	$ 1,500	$ 3,000	$ 3,000	$ 6,000
	$ 2,500	$ 5,000	$ 5,000	$ 10,000
	$ 3,500	$ 7,000	$ 7,000	$ 14,000
	$ 5,000	$ 10,000	$ 10,000	$ 20,000
	$ 5,950	$ 11,900	$ 11,900	$ 23,800
Coinsurance – The percentage of covered healthcare costs you have to pay while covered under this plan	Plan pays 100% of covered expenses after you pay your deductible		You pay 30% of covered expenses after you pay your deductible	
Your out-of-pocket coinsurance maximum – The amount you're required to pay toward the covered cost of your healthcare; premium and deductibles don't apply	Individual: $ 0	Family: $ 0	Individual: $ 7,500	Family: $ 15,000
	Each covered persons coinsurance applies to meet this maximum			
Lifetime maximum – The total amount your plan will pay for covered expenses in your lifetime	❑ $5 million per covered person (included in plan) ❑ $8 million per covered person (increased maximum available for an extra cost)			

Important to know:
- Deductibles start over each new calendar year
- Benefits will be paid once the family deductible is met, regardless of the number of members on the plan
- This plan may include a separate deductible for certain conditions; see the deductible information on page 4 for details
- The medical deductible is separate from other deductibles; expenses applied to the medical deductible won't apply to mental health, prescription drugs, or condition-specific deductibles

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

AZ-52419-HO 4/10

Humana*One* Enhanced HSA 100% plan

How your plan works

The details below give you a general idea of covered benefits for this plan. It doesn't explain everything. To be covered, expenses must be medically necessary and listed as covered in your Certificate. A certificate is a document which outlines the benefits, provisions, and limitations of your plan. Please refer to a Certificate for the actual terms and conditions of your plan. This plan also has things that are not covered or limited. You should know about these. See page 4 for details.

	In-network	Out-of-network
Preventive care – includes preventive: office visits, child immunizations (other than HPV and Meningococcal), Pap smear, and mammogram **Important to know:** › In-network preventive Pap smear and mammogram apply to but are not limited by the $500 maximum	The plan pays 100% up to a maximum of $500 per covered person per calendar year	You pay 30% after you pay your deductible
Office visits **Important to know:** › Does not include preventive office visits	The plan pays 100% after you pay your deductible for a primary care physician, specialist, or urgent care visit	You pay 30% after you pay your deductible
Lab and X-rays	Plan pays 100% after you pay your deductible	You pay 30% after you pay your deductible
Inpatient hospital and outpatient services Note: doctors and hospitals often send separate bills	Plan pays 100% after you pay your deductible	You pay 30% after you pay your deductible
Emergency room	Plan pays 100% after you pay your deductible	Plan pays 100% after you pay your deductible
Ambulance	Plan pays 100% after you pay your deductible	Plan pays 100% after you pay your deductible
	The plan pays up to $15,000 per calendar year (this includes both in- and out-of-network services).	
Transplants	Plan pays 100% after you pay your deductible when you get services from a Humana Transplant Network provider	You pay 30% after you pay your deductible. Plan pays up to $35,000 per transplant
Mental health (mental illness and chemical dependency) – includes inpatient and outpatient services **Important to know:** › There is a 12-month waiting period before this plan pays benefits › The mental health deductible is separate from other deductibles; expenses applied to the mental health deductible won't apply to the other deductibles for your plan such as medical, prescription drugs, or certain illnesses	You first pay your mental health deductible, which is the same amount as your in-network medical deductible Then, plan pays 100%	You first pay your mental health deductible, which is the same amount as your out-of-network medical deductible Then, you pay 30%
	The plan pays up to $2,500 per calendar year. (this includes both in- and out-of-network services). Outpatient services are limited to $500 per calendar year of the overall $2,500. Covered expenses for mental health don't apply to the medical out-of-pocket maximum.	
Other medical services **Important to know:** › Spinal manipulations, adjustments, and modalities performed by a Chiropractor apply to but are not limited by the 10 visit maximum	Plan pays 100% after you pay your deductible	You pay 30% after you pay your deductible
	These services are covered with the following combined in- and out-of-network limits: • Skilled nursing facility – up to 30 days per calendar year • Home health care • Hospice family counseling – up to 15 visits per family per lifetime • Hospice medical social services – up to $100 per family per lifetime • Physical, occupational, cognitive, speech, audiology, cardiac, and respiratory therapy – combined, up to 30 visits per calendar year • Spinal manipulations, adjustments, and modalities – up to 10 visits per calendar year	

Your prescription drug coverage

	In-network	Out-of-network
Prescription drugs **Important to know:** › If you use an out-of-network pharmacy, you'll need to pay the full cost up front and then ask Humana to pay you back by submitting a claim › Prescription drug deductible is integrated with your medical deductible and out-of-pocket coinsurance maximum › Find details about Humana's preferred mail-order service at **RightSourceRx.com**	Your plan pays 100% after you pay your deductible	You pay 30% after you pay your deductible.

Make your Humana*One* plan fit your needs even better. Extra benefits are an easy and affordable way to get the coverage you need. Plus, in most cases, there's no separate application or underwriting.

Add extra benefits to your medical plan

The following benefits are available to you at an extra cost.

Dental

Protect your healthy smile with affordable, easy-to-use optional dental benefits from one of the nation's largest dental insurers. For a low monthly premium, you can use more than 130,000 network providers. And if you're approved for a medical plan, you're approved for dental benefits – just choose the type of coverage that meets your needs:

- ❑ **Traditional Plus** includes coverage for preventive, basic, and major services. You can go to network or non-network dentists, but you'll pay less when you choose dentists in the network.
- ❑ **Preventive Plus** covers the most common preventive and basic services. Discounts are available for major services and basic services the plan doesn't cover.

Term life

Humana*One* makes it easy to get peace of mind and help plan for a secure future for your family. You can apply for a health plan and term life insurance at the same time. If you are approved for your health plan, you will also be eligible for up to $150,000 term life coverage. Term life insurance gives protection for a certain time, during which premiums stay the same.

Supplemental accident

With this extra benefit, the plan pays a set amount per covered person for treatment of an accident, excluding prescription drugs, even before you've met the plan deductible. Treatment must take place within 90 days of the accident.

- ❑ **$1,000:** Plan pays first $1,000 per accident at 100%, then your plan benefits apply
- ❑ **$2,500:** Plan pays first $2,500 per accident at 100%, then your plan benefits apply

Contact your agent for plan details or more information.

Insured by HumanaDental Insurance Company, Humana Insurance Company

Condition-specific deductibles (deductibles for certain illnesses)

This plan may include condition-specific deductibles, or CSDs, of $2,500, $5,000, or $7,500 in-network ($5,000, $10,000, or $15,000 out-of-network). CSDs allow you to get coverage for services that wouldn't be covered otherwise or would have a waiting period. The CSD applies to certain conditions listed in your Certificate. If you have any of these conditions before your coverage starts, you'll have coverage for these services – you just need to meet the separate deductible first. After you meet the CSD, your plan will pay for covered expenses related to the condition at 100% for the rest of the calendar year. Prescriptions used to treat the condition don't apply to the CSD.

Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Network providers aren't the agents, employees, or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana doesn't provide medical services. Humana doesn't endorse or control your healthcare providers' clinical judgment or treatment recommendations. Your Certificate explains your share of the cost for network and out-of-network providers. It may include a deductible, a set amount (copayment or access fee), and a percent of the cost (coinsurance).

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider can't "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay is based on Humana's maximum allowable fee.
- The provider can "balance bill" you for charges greater than the maximum allowable fee. These charges don't apply to your out-of-pocket limit or deductible.

Pre-existing conditions

A pre-existing condition is a sickness or bodily injury for which, during the five-year period immediately prior to the covered person's effective date of coverage: 1) the covered person sought, received or was recommended medical advice, consultation, diagnosis, care or treatment; 2) prescription drugs were prescribed; 3) signs or symptoms were exhibited; or 4) diagnosis was possible. 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 enrollment form provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the Humana*One* individual health plan listed above. It is designed for convenient reference. Consult the Certificate for a complete list of limitations and exclusions. Your Certificate is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the Certificate. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and billing exclusions

- Services incurred before the effective date, after the termination date, or when premium is past due
- Charges in excess of the maximum allowable fee
- Charges in excess of the lifetime maximum benefit or any other benefit maximum
- Services not authorized, furnished, or prescribed by a healthcare provider
- Services for which no charge is made
- Services provided by a family member or person who resides with the covered person
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary
- Services not medically necessary, except for routine preventive services as stated in the Certificate

Elective and cosmetic services

- Cosmetic services, or any related complication
- Elective medical or surgical procedures
- Hair prosthesis, hair transplants, or hair implants
- Prophylactic services

Immunizations

- Immunizations except as stated in the Certificate

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury), appliances, or supplies
- Foot care services
- Hearing care that is routine
- Vision examinations or testing, eyeglasses, or contact lenses

Pregnancy and sexuality services

- Pregnancy except for complications of pregnancy as defined in the Certificate. Complications of pregnancy does NOT mean: False labor, occasional spotting, rest prescribed during the period of pregnancy, morning sickness, conditions associated with the management of a difficult pregnancy, but which do not constitute a distinct complication of pregnancy, prolonged labor, cessation of labor, breech baby, fetal distress, edema, or complicated delivery.
- Lactation therapy
- Elective medical or surgical abortion except as stated in the Certificate
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- Sterilization, including tubal ligation and vasectomy, and reversal of sterilization
- Infertility services
- Sex change services and sexual dysfunction
- Services rendered in a premenstrual syndrome clinic

Obesity-related services

- Any treatment for obesity
- Surgical procedures for the removal of excess skin and/or fat due to weight loss

Illness/injury circumstances

- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated in the Certificate
- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, influence of an illegal substance, being intoxicated, or engaging in an illegal occupation

Care in certain settings

- Private duty nursing
- Custodial or maintenance care
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected sickness or bodily injury

Hospital services

- Services received in an emergency room unless required because of emergency care
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted
- Hospital inpatient services when the covered person is in observation status or when stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health

Mental health services

- Court-ordered mental health services
- Services and supplies that are rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services
- Services and supplies that are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation
- Marriage counseling

Other payment available

- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law
- Charges for which any other insurance providing medical payments exists

Services not considered medical

- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner

Other

- Any expense incurred for services received outside of the United States while residing outside of the United States for more than six consecutive months in a year except as required by law for emergency care services
- Biliary lithotripsy
- Chemonucleolysis
- Charges for growth hormones
- Cranial banding, unless otherwise determined by us
- Educational or vocational training or therapy, services, and schools
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations
- Genetic testing, counseling, or services
- Hyperhydrosis surgery
- Immunotherapy for food allergy
- Light treatment for Seasonal Affective Disorder (S.A.D.)
- Living expenses, travel, transportation, except as expressly provided in the Certificate
- Prolotherapy
- Sensory integration therapy
- Services for care or treatment of non-covered procedures, or any related complication
- Alternative medicine including but not limited to holistic medicine, acupuncture, and naturopathy
- Services that are experimental, investigational, or for research purposes
- Sleep therapy
- Treatment for TMJ, CMJ, or any jaw joint problem
- Treatment of nicotine habit or addiction
- Any drug, medicine or device which is not FDA approved
- Medications, drugs or hormones to stimulate growth
- Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered injury or sickness
- 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
- Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription
- Drugs used in treatment of nail fungus
- Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order
- Vitamins, dietary products, and any other nonprescription supplements

Certain services and prescription drugs require preauthorization and notification/prior authorization before services are rendered. Please visit Humana.com/members/tools for a detailed list.

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.

This document contains a general summary of covered benefits, exclusions and limitations. Please refer to the 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 Certificate will govern.

Your premium won't go up during the first year the Certificate is in force, as long as you stay in the same area and keep the same benefits. After the first year, we have the right to raise premiums on your renewal date, or more frequently if you move out of the service area or change benefits.

HUMANA *one*®

AZ-52419-HO 4/10
Certificate number: AZ-70155-01 4/2010, et al.