

Limitations and Exclusions

This is an outline of the limitations and exclusions for the HumanaOne Individual Health Plan. It is designed for convenient reference and may vary by state. Consult the policy for a complete list of limitations and exclusions.

Unless stated otherwise, no services will be provided for the following situations.

1. Services not medically necessary for diagnosis and treatment of a bodily injury or sickness;
2. Any service which is experimental, investigational, or for research purposes, unless otherwise indicated in the policy;
3. Services of ineligible providers;
4. Services not authorized or prescribed by a health care practitioner;
5. Services for which no charge is made;
6. Services while confined in a hospital or other facility owned or operated by the United States government;
7. Services provided by a person who ordinarily resides in the covered person's home or who is a family member;
8. Services that are performed in association with a service that is not covered under this policy;
9. Charges in excess of the maximum allowable fee for the service;
10. Pre-existing conditions to the extent specified in the policy;
11. Expenses incurred before the effective date or after the date the coverage terminates;
12. Any expense incurred exceeding any policy benefit maximum;
13. Cosmetic surgery except for breast reconstruction following a medically necessary mastectomy, or for congenital defects for a covered dependent;
14. Custodial care and maintenance care;
15. Any drug, medicine or device which does not have the U.S. Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval or 510K;
16. Contraceptives, other than oral, including implant systems and devices regardless of the purpose for which prescribed;
17. Medications, drugs or hormones to stimulate growth;
18. a. Prescription drugs received before the effective date and after the termination date.
b. Legend drugs not recommended or deemed necessary by a health care practitioner; drugs prescribed for a non-covered sickness or bodily injury.
c. 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.
d. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
e. Drugs used in treatment of nail fungus
f. Prescription refills exceeding the number specified by the health care practitioner or dispensed more than one year from the date of the original order;
19. Vitamins, dietaries and any other nonprescription supplements;
20. Infertility services;
21. Treatment of normal pregnancy and well-baby expenses unless otherwise indicated in the policy;
22. Elective medical or surgical abortion, reversal of elective sterilization or any services associated with gender reassignment or sexual dysfunction;
23. Vision therapy; all types of refractive keratoplasties; any other procedures, treatments or devices for refractive correction, eyeglasses and contact lenses;
24. Routine physical, hearing and eye examinations for occupation, employment, school, travel, purchase of insurance or premarital tests;
25. Dental/orthodontic services or supplies unless otherwise indicated in the policy;
26. Any loss contributed to, or caused by, war or any act of war, whether declared or not;
27. Treatment of mental disorders, chemical or alcohol dependence unless otherwise indicated in the policy;
28. Private duty nursing;
29. Loss due to commission or attempt to commit a civil or criminal battery or felony;
30. Services rendered by a standby physician or assistant surgeon, unless medically necessary;
31. Environmental medicine;
32. Treatment of obesity, unless qualified as morbid obesity;
33. Smoking cessation programs, medications, aids or devices;
34. Educational or vocation therapy, services and schools;
35. Foot care services unless otherwise indicated in the policy;
36. Communications and travel time;
37. Lodging accommodations or transportation;
38. Charges for services that are primarily and customarily used for nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician);
39. Light treatments for Seasonal Affective Disorder (S.A.D.);
40. Charges for health clubs or health spas, aerobic and strength conditioning;
41. Hearing aids, hair prosthesis, hair transplants or implants and wigs;
42. Alternative medicine;
43. Marital counseling;
44. Transplant services, except as specified in this policy;
45. Treatment for any jaw joint problem, including but not limited to, temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull;
46. Services for an injury or illness covered by workers' compensation or similar benefits;
47. Genetic testing, counseling or services;
48. Counseling or behavioral modification services;
49. Treatment as a result of attempted suicide or intentionally self-inflicted injury, while sane or insane;
50. Charges for which there is an automobile or liability insurance providing medical payments; or
51. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

A copy of the Colorado Network Access plan can be provided upon request.

