Autograph: Total / HSA

HUMANA one

Georgia

		Plan pays for services from **NETWORK** providers	Plan pays for services from **NON-NETWORK** providers
Deductible options[1] • per calendar year • copayments do not apply	• individual	$2,000/$3,000/$4,000/$5,200	$4,000/$6,000/$8,000/$10,400
	• family[2]	$4,000/$6,000/$8,000/$10,400	$8,000/$12,000/$16,000/$20,800
Coinsurance out-of-pocket limit[1] • deductibles and copayments do not apply	• individual	Not applicable	$6,000
	• family	Not applicable	$12,000
Preventive care	• child wellness services through age 5	100%	70%
	• preventive lab and X-ray[3] • preventive office visits[3] • child immunizations age 6 to 18[3] • Pap smear and mammogram • prostate screening • colorectal cancer screening exams and lab tests • screening test for ovarian cancer • chlamydia screening test	100%	70% after deductible
Physician services	• office visits • diagnostic lab and X-ray • allergy injections, testing and serum • inpatient and outpatient services • surgery	100% after deductible	70% after deductible
Facility services	• inpatient/outpatient services and outpatient surgery	100% after deductible	70% after deductible
	• emergency services	100% after deductible	100% after deductible
Prescription drug	• retail or mail order benefit for each prescription or refill	Discounts available[4]	Not covered
Other medical services • Prior authorization required in order to be eligible for these benefits	• skilled nursing facility (up to 30 days per calendar year) • hospice[5] • home health care (up to 60 visits per calendar year) • durable medical equipment • pregnancy complications and sick baby services	100% after deductible	70% after deductible
	• transplant services	100% after deductible when services are received from a Humana Transplant Network provider	70% after deductible covered expenses are limited to a maximum allowance of $35,000 per transplant
Lifetime maximum benefit		Unlimited	
Optional benefits • these are available to add for an additional cost	• supplemental accident benefit ($500 or $1,000) (treatment must be provided within 90 days of the injury)	First $500 per accident at 100%, then base plan benefits apply or First $1,000 per accident at 100%, then base plan benefits apply	
	• mental health, chemical, and alcohol dependency (replaces base mental health benefits if chosen) —Inpatient (up to 30 days per calendar year per covered person) —Outpatient therapy (up to 48 visits per calendar year per covered person)	100% after deductible	70% after deductible

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

1. When you obtain care from non-network providers:
   - 50 percent of your payment toward the deductible is credited to the deductible for network providers
   - 50 percent of your out-of-pocket costs are credited to the out-of-pocket maximum for network providers

   Once you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
2. For other than single coverage, the family deductible applies. The single deductible applies to single coverage policies only.
3. Benefit payable after 90-day waiting period for preventive care and 12-month waiting period for mental health.
4. This value-added feature is not insurance. There is no coverage for retail and/or mail order prescription drugs unless stated in the policy.
5. Counseling for the hospice patient and immediate family is limited to 15 visits per family per lifetime. Medical Social Services limited to $100 per family per lifetime.

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Georgia Autograph: Total / HSA

Payments

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

Non-network providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Network primary care and specialist physicians and other providers in Humana's networks are not the agents,employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgement or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

Medical limitations and exclusions

This is an outline of the limitations and exclusions for Humana*One* individual health plans. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. Your policy is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the policy.

Eligibility

The issue ages for Humana*One* individual health plans are two months to 64.5 years. A dependent child must be less than 26 years of age to apply.

Pre-existing conditions

A pre-existing condition is a sickness or injury which was diagnosed or treated, or which produced signs or symptoms that would cause an ordinarily prudent person to seek treatment, during the five-year period before the covered person's effective date of coverage. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with us. We will waive the pre-existing conditions limitation for those conditions disclosed on the application provided benefits relating to those conditions are not excluded. Conditions specifically excluded by rider are never covered. The pre-existing condition limitation does not apply to a covered person who is under the age of 19.

Other expenses not covered

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

1. Services not medically necessary or which are experimental, investigational or for research purposes.
2. Services not authorized or prescribed by a healthcare practitioner or for which no charge is made.
3. Services while confined in a hospital or other facility owned or operated by the United States government, provided by a person who ordinarily resides in the covered person's home or who is a family member, or that are performed in association with a service that is not covered under the policy.
4. Charges in excess of the maximum allowable fee or which exceed any policy benefit maximum.
5. Expenses incurred before the effective date or after the date coverage terminated.
6. Cosmetic procedures and any related complications except as stated in the policy.
7. Custodial or maintenance care.
8. Infertility services.
9. Pregnancy and well-baby expenses.
10. Elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; abortion; gender change or sexual dysfunction.
11. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses; hearing aids; dental exams.
12. Hearing and eye exams; routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests other than newborn hearing screening.
13. Services received in an emergency room unless required because of emergency care.
14. Dental services (except for dental injury or dental anesthesia services for a dependent child under certain conditions), appliances or supplies.
15. War or any act of war, whether declared or not; commission or attempt to commit a civil or criminal battery or felony.
16. Standby physician or assistant surgeon, unless medically necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the policy.
17. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat sickness or injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures unless qualified as morbid obesity.
18. Nicotine habit or addiction; educational or vocation therapy, services and schools; light treatment for Seasonal Affective Disorder (S.A.D.); alternative medicine; marital counseling; genetic testing, counseling or services; sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
19. Foot care services.
20. Charges for nonmedical purposes or used for environmental control or enhancement (whether or not prescribed by a healthcare practitioner).
21. Health clubs or health spas, aerobic and strength conditioning, work hardening programs and related material and products for these programs; personal computers and related or similar equipment; communication devices other than due to surgical removal of the larynx or permanent lack of function of the larynx.
22. Hair prosthesis, hair transplants or implants and wigs.
23. Injury or sickness arising out of or in the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to a covered person qualifying as a sole proprietor, officer or partner under state law, and such benefits are not covered under any Workers' Compensation plan, provided the covered person is not covered under a Workers' Compensation plan, except for certain professions or activities as stated in the policy.
24. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
25. Charges covered by other medical payments insurance.
26. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
27. Charges incurred for a hospital stay beginning on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.
28. Mental health including mental disorders, alcohol and chemical dependency.
29. Spinal manipulations and spinal adjustment modalities.
30. 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 or as stated in the policy.
31. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions.

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HUMANA one

Insured by Humana Employers Health Plan of Georgia, Inc. and Humana Insurance Company
Applications are subject to approval. Waiting periods, limitations and exclusions apply.

This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.

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Policy number: GA-70142 9/2006, et al.

Dental Traditional Plus

HUMANA one

Good health starts with a healthy mouth. Regular cleanings can reduce the likelihood of developing gum disease which has been linked to other serious conditions such as heart disease, diabetes, and stroke. Our Traditional Plus dental plan focuses on prevention, early diagnosis, and treatment—helping you stay healthy and fit. Because Humana has one of the largest PPO dental networks, with over 125,000 participating dentists, you're sure to find a dentist you knowand trust who practices near your home or work.

Traditional Plus plan features:

- Preventive services covered at 100%
- Basic services are covered at 50% (after your deductible)
- Major services are covered at 50% (after your deductible)
- Coverage at the same rate when using network or non-network providers
- Savings up to 30% by choosing network dentists
- Coverage for teeth whitening (not available FL)

Calendar-year deductible		**Individual** $50	**Family** $150
Annual maximum		$1,000	
		Plan pays for services from **NETWORK** providers	Plan pays for services from **NON-NETWORK** providers
Preventive services	• oral examinations • cleanings • topical fluoride treatment (through age 14, one per calendar year) • sealants (through age 14) • bitewing x-rays • panoramic x-rays	100% no deductible	100% no deductible
Basic services • six month waiting period applies	• emergency care for pain relief • nonsurgical extractions • fillings (amalgam, composite for anterior teeth) • space maintainers • oral surgery • prefabricated stainless steel crowns • appliances for children (through age 14) • denture repair and adjustments	50% after deductible	50% after deductible
Major services • twelve month waiting period applies	• denture relines and rebases • dentures • endodontics (root canals) • periodontics (gum therapy) • crowns • inlays and onlays • bridgework	50% after deductible	50% after deductible
Orthodontia	• Members can receive up to a 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount.		
Teeth whitening • six month waiting period applies	• $200 lifetime maximum	50% after deductible	50% after deductible

This is not a complete disclosure of plan qualifications and limitations. Waiting periods and frequency/age limits may apply. Please review the specific dental limitations and exclusions on the back before applying for coverage. Your billing and effective date for this plan will be the same as your medical plan and your dental premium will be collected along with your medical premium.

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Dental Limitations and Exclusions

This is an outline of the limitations and exclusions for the Humana*One* Dental Traditional Plus dental plan. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions.

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

1. The course of any occupation or employment for compensation, profit or gain, for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law; or where such coverage was available, regardless of whether the coverage was actually applied for.
2. Services and supplies for which no charge is made, or for which the covered person would not be required to pay in the absence of insurance.
3. Services furnished by or payable under any plan or law through any Government or any political subdivision.
4. Services furnished by any hospital or institution owned or operated by the United States Government, unless legally required to pay.
5. War or any act of war, whether declared or not; or any act of international armed conflict or any conflict involving armed forces of any international authority.
6. Completion of forms or failure to keep an appointment with a dentist.
7. Cosmetic dentistry, except as stated in the policy.
8. Any service related to altering vertical dimension; restoration or maintenance of occlusion; splinting teeth; replacing tooth structures lost as a result of abrasion, attrition or erosion; or bite registration or bite analysis.
9. Bone grafts, regeneration, augmentation or preservative procedures in edentulous sites.
10. Implants, including any crowns or prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with it; or other customized attachments.
11. Infection control.
12. Fees for treatment by other than a dentist, except as stated in the policy.
13. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
14. Prescription drugs or pre-medications, whether dispensed or prescribed.
15. Any service not listed as a covered expense.
16. Any service not considered a dental necessity, does not offer a favorable prognosis, does not have uniform professional endorsement, or is experimental or investigational in nature.
17. Expenses incurred prior to the effective date or after the date coverage is terminated, except for any extension of benefits.
18. Services provided by a person who ordinarily resides in the covered person's home or who is a family member.
19. Charges in excess of the reimbursement limit for the service or supply.
20. Treatment as a result of an intentionally self-inflicted injury or bodily illness, while sane or insane.
21. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with impression or placement of a restoration, charged as a separate service.
22. Repair and replacement of orthodontic appliances.

HUMANA *one*®

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

This document contains a general summary of benefits, exclusions and limitations. Please refer to the policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the policy will govern.

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