

Autograph: Share 70 Plus Rx



Georgia

		Plan pays for services from NETWORK providers	Plan pays for services from NON-NETWORK providers								
Deductible options¹ • per calendar year • copayments do not apply	• individual	\$2,500 or \$5,000	\$5,000 or \$10,000								
	• family (two family members must each meet their individual deductible)	\$5,000 or \$10,000	\$10,000 or \$20,000								
Deductible carryover	Covered expenses incurred in the last three months of the calendar year and applied to the deductible will be credited to the next calendar year deductible.										
Coinsurance out-of-pocket limit¹ • per calendar year • deductibles and copayments do not apply	• individual	\$3,000	\$10,000								
	• family	\$6,000	\$20,000								
Preventive care	• child wellness services through age 5	70%	60%								
	• preventive lab and X-ray ^{2,3}	70% after deductible	60% after deductible								
	• preventive office visits ^{2,3}	70%	60% after deductible								
	• child immunizations age 6 to 18 ^{2,3} • Pap smear and mammogram • prostate screening • colorectal cancer screening exams and lab tests • screening test for ovarian cancer • chlamydia screening test										
Physician services	• office visits (including allergy injections)	70% after deductible	60% after deductible								
	• diagnostic lab and X-ray ⁴										
	• allergy testing										
	• allergy serum										
	• inpatient and outpatient services • surgery										
Facility services	• inpatient/outpatient services and outpatient surgery	70% after deductible	60% after deductible								
	• emergency services (copayment waived if admitted)	70% after \$125 copayment per visit and deductible	70% after \$125 copayment per visit and deductible ⁵								
Rx4 prescription drug⁶ • medical out-of-pocket maximum does not apply	• deductible per individual		Separate \$1,000 deductible								
	• benefit for each prescription or refill (up to 90-day supply; with applicable copay for each 30 day supply)		<table border="1"> <thead> <tr> <th>Level 1</th> <th>Level 2</th> <th>Level 3</th> <th>Level 4</th> </tr> </thead> <tbody> <tr> <td>\$15*</td> <td>\$40</td> <td>\$65</td> <td>25%</td> </tr> </tbody> </table>	Level 1	Level 2	Level 3	Level 4	\$15*	\$40	\$65	25%
	Level 1	Level 2	Level 3	Level 4							
	\$15*	\$40	\$65	25%							
• copayment maximum (applies to Level 4 drugs only)			*Level 1 drugs subject to copay, no deductible \$2,500 per individual per calendar year								
• benefit per prescription or refill	100% after prescription copayment	100% after prescription copayment									
• mail order (up to 90-day supply)	100% after three times retail copay	100% after three times retail copay									
Other medical services • prior authorization required in order to be eligible for these benefits	• skilled nursing facility (up to 30 days per calendar year)	70% after deductible	60% after deductible								
	• hospice ⁷ • home health care (up to 60 visits per calendar year) • durable medical equipment • pregnancy complications and sick baby services (no prior authorization required)										
	• transplant services	70% after deductible when services are received from a Humana Transplant Network provider	60% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant								
Lifetime maximum benefit	\$2,000,000 per covered person										
Mental health, chemical and alcohol dependency² • \$2,500 per calendar year • medical out-of-pocket maximum does not apply	• inpatient services	50% after deductible	50% after deductible								
	• outpatient and office therapy sessions (outpatient services not to exceed \$500 of the total benefit)										
Optional benefits • these are available to add for an additional cost • medical out-of-pocket maximum does not apply to drug coverage	• prescription drug deductible	Not available with this plan									
	• lifetime maximum	Increase to \$5,000,000 per covered person									
	• 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)	70% after deductible	60% after deductible								

continued >

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

1. When you obtain care from non-network providers:
 - 50 percent of your payment toward the deductible is credited to the deductible for network providers
 - 50 percent of your out-of-pocket costs are credited to the out-of-pocket maximum for network providersOnce you meet your deductible and out-of-pocket expense limits, the plan pays 100 percent for covered services.
2. Benefit payable after 90-day waiting period for preventive care and 12-month waiting period for mental health.
3. Benefit maximum for preventive care is limited to \$300 per person per calendar year, subject to applicable coinsurance.
4. MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
5. Emergency care provided by a non-network provider will be covered at the network provider benefit level until the covered person can be safely transported to a network provider.
6. If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
7. Counseling for the hospice patient and immediate family is limited to 15 visits per family per lifetime. Medical Social Services limited to \$100 per family per lifetime.

Payments

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

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

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

Medical limitations and exclusions

This is an outline of the limitations and exclusions for HumanaOne 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 HumanaOne individual health plans are two months to 64.5 years. The maximum age for a dependent child is 25 years if the child is a full-time student and 19 years if the child is not a full-time student.

Pre-existing conditions

A pre-existing condition is a sickness or injury 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.

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, unless legally required to pay, 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. Termination of policy will not prejudice an existing claim that commenced prior to the date of termination.
6. Cosmetic procedures and any related complications except as stated in the policy.
7. Custodial or maintenance care.
8. Infertility services, except diagnosis.
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 (except for the medically necessary treatment of diabetes).
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.
24. Attempted suicide or intentionally self-inflicted injury, whether sane or insane.
25. Organ transplants not approved based on established criteria or investigational, experimental or for research purposes.
26. Charges incurred for a hospital stay beginning on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.
27. Any drug, medicine or device which is not FDA approved, except as stated in the policy.
28. Medications, drugs or hormones to stimulate growth.
29. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a noncovered injury or sickness.
30. 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.
31. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
32. Drugs used in treatment of nail fungus.
33. Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
34. Vitamins, dietary products and any other nonprescription supplements.
35. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions not a result of a mental disorder.



Insured by Humana Employers Health Plan of Georgia, Inc. and Humana Insurance Company
Applications are subject to approval. Waiting periods, limitations and exclusions apply.
The HumanaOne brand of individual products are insured by subsidiaries of Humana, Inc.

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

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