

Portrait: Share 80 Plus Rx Unlimited



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	\$1,000 or \$2,500	\$2,000 or \$5,000
	• family (two family members must each meet their individual deductible)	\$2,000 or \$5,000	\$4,000 or \$10,000
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.		
Office visit copayment		\$35 primary care/\$50 specialist unlimited visits for illness or injury	Not applicable
Coinsurance out-of-pocket limit¹ • per calendar year • deductibles and copayments do not apply	• individual	\$2,000	\$8,000
	• family	\$4,000	\$16,000
Preventive care	• child wellness services through age 5	100%	70%
	• preventive lab and X-ray ² • preventive office visits ² • child immunizations age 6 to 18 ² • 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 (including allergy injections)	100% after office visit copayment	60% after deductible
	• diagnostic lab and X-ray ³ • allergy testing	First \$200 per calendar year 100% then 80% after deductible	60% after deductible
	• allergy serum • inpatient and outpatient services • surgery	80% after deductible	60% after deductible
Facility services	• inpatient/outpatient services and outpatient surgery	80% after deductible	60% after deductible
	• emergency services (copayment waived if admitted)	80% after \$75 copayment per visit and deductible	80% after \$75 copayment per visit and deductible
Rx4 prescription drug⁴ • medical out-of-pocket maximum does not apply	• deductible per individual • benefit for each prescription or refill (up to 90-day supply; with applicable copayment for each 30 day supply)	Separate \$500 deductible	
		Level 1 \$15*	Level 2 \$35
		Level 3 \$55	Level 4 25%
	• copayment maximum (applies to Level 4 drugs only)	*Level 1 drugs subject to copayment, 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 copayment	100% after three times retail copayment	
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	80% after deductible	60% after deductible
	• transplant services	80% after deductible when services are received from a Humana Transplant Network provider	60% after deductible covered expenses are limited to a maximum allowance of \$35,000 per transplant
Lifetime maximum benefit			Unlimited
Mental health, chemical and alcohol dependency² • medical out-of-pocket maximum does not apply	• inpatient services • outpatient and office therapy sessions	50% after deductible	50% after deductible

Georgia Portrait: Share 80 Plus Rx Unlimited

Optional benefits			
<ul style="list-style-type: none">• these are available to add for an additional cost• medical out-of-pocket maximum does not apply to drug coverage	<ul style="list-style-type: none">• prescription drug deductible		With this option no deductible is required before Rx benefits are payable
	<ul style="list-style-type: none">• 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
	<ul style="list-style-type: none">• mental health, chemical, and alcohol dependency (replaces base mental health benefits if chosen)<ul style="list-style-type: none">—Inpatient (up to 30 days per calendar year per covered person)—Outpatient therapy (up to 48 visits per calendar year per covered person)		80% 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.

- 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.
- Benefit payable after 90-day waiting period for preventive care and 12-month waiting period for mental health.
- MRI, CAT, EEG, EKG, ECG, cardiac catheterization or pulmonary function studies are subject to applicable coinsurance after deductible.
- If a non-network pharmacy is used you must pay 100 percent of the actual charges and file a claim with Humana for reimbursement.
- 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. 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. Any drug, medicine or device which is not FDA approved.
29. Medications, drugs or hormones to stimulate growth.
30. Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a noncovered injury or sickness.
31. 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.
32. Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
33. Drugs used in treatment of nail fungus.
34. Prescription refills exceeding the numbers specified by the healthcare practitioner or dispensed more than one year from the date of the original order.
35. Vitamins, dietary products and any other nonprescription supplements.
36. 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.

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.

GA51531HO 910

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

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 know and 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	Family
		\$50	\$150
Annual maximum		\$1,000	
		Plan pays for services from NETWORK providers	Plan pays for services from NON-NETWORK providers
Preventive services	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • denture relines and rebases • dentures • endodontics (root canals) • periodontics (gum therapy) • crowns • inlays and onlays • bridgework 	50% after deductible	50% after deductible
Orthodontia	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • \$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.

Dental Limitations and Exclusions

This is an outline of the limitations and exclusions for the HumanaOne 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 anesthesiologist.
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.



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 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.

Dental care is an important part of maintaining good overall health. Our Preventive Plus plan encourages preventive treatment, which helps keep your mouth healthy while minimizing your costs. And, because Humana has one of the largest PPO dental networks, with over 125,000 participating dentists, you're sure to find a dentist you know and trust who practices near your home or work.

Preventive Plus plan features:

- › Preventive services covered at 100%
- › Many commonly used basic services are covered at 50% (after your deductible)
- › Substantial discounts on other basic and major services when using network providers
- › Savings up to 30% by choosing network dentist

Important to note:

This plan requires a one-time, non-refundable enrollment fee. The effective date will be the first of the month following the issuance of your medical policy and may differ from your medical effective date. This plan also requires monthly membership in an association. See below for details.

Calendar-year deductible (deductible does not apply to discount services)		Individual \$50	Family \$150
Annual maximum (annual maximums does not apply to discount services)		\$1,000	
		Plan pays for services from NETWORK providers	Plan pays for services from NON-NETWORK providers
Preventive services	<ul style="list-style-type: none"> • oral examinations • cleanings • topical fluoride treatment (through age 14, one per calendar year) • sealants (through age 14) • bitewing x-rays 	100% no deductible	70% of in network fee schedule* (after deductible)
Basic services	<ul style="list-style-type: none"> • emergency care for pain relief • nonsurgical extractions • fillings (amalgam, composite for anterior teeth) • space maintainers • oral surgery • prefabricated stainless steel crowns 	50% after deductible	30% of in network fee schedule* (after deductible)
Discount services	<ul style="list-style-type: none"> • appliances for children (through age 14) • denture repair and adjustments • denture relines and rebases • dentures • endodontics (root canals) • periodontics (gum therapy) • crowns • inlays and onlays • bridgework • implants 	These services are not covered under this plan, however, you can receive discounts on these services if you see our network dentists. Out-of-pocket expenses do not apply to deductible and annual maximum.	No discount
Orthodontia	<ul style="list-style-type: none"> • Members can receive up to a 20 percent discount if they visit an orthodontist from the HumanaDental PPO Network and ask for the discount. 		

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.

*** Understanding the network fee schedule charge:** If you visit a non-network dentist, the coinsurance will be applied to a pre-determined average for the cost of services within your area; not necessarily what your dentist charges. That means, your dentist can bill you for additional charges above the amount covered by your plan. To ensure you don't receive additional charges, visit a Network provider.

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 a Dental Preventive Plus plan.

Dental Limitations and Exclusions

This is an outline of the limitations and exclusions for the HumanaOne Dental Preventive Plus dental plan. It is designed for convenient reference. Consult the certificate for a complete list of limitations and exclusions.

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

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - A. That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - B. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - C. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - A. War or any act of war, whether declared or not;
 - B. Any act of international armed conflict; or
 - C. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under the policy. We consider the following cosmetic dentistry procedures:
 - A. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
 - B. Any service to correct congenital malformation;
 - C. Any service performed primarily to improve appearance; or
 - D. Characterizations and personalization of prosthetic devices.
7. Charges for:
 - A. Any type of implant and all related services, including crowns or the prosthetic device attached to it.
 - B. Precision or semi-precision attachments.
 - C. Overdentures and any endodontic treatment associated with overdentures.
 - D. Other customized attachments.
8. Any service related to:
 - A. Altering vertical dimension of teeth;
 - B. Restoration or maintenance of occlusion;
 - C. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth;
 - D. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction;
 - E. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in your plan benefits.
14. Any service shown as "Not Covered" in the Schedule.
15. Any service that we determine:
 - A. Is not a dental necessity;
 - B. Does not offer a favorable prognosis;
 - C. Does not have uniform professional endorsement; or
 - D. Is deemed to be experimental or investigational in nature.
16. Orthodontic services.
17. Any expense incurred before your effective date or after the date your coverage under the policy terminates.
18. Services provided by someone who ordinarily lives in your home or who is a family member.
19. Charges exceeding the reimbursement limit for the service.
20. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
21. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
22. Repair and replacement of orthodontic appliances.
23. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
24. Elective removal of non-pathologic impacted teeth.



Insured by Humana Insurance Company or HumanaDental 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.