HumanaOne®
Value 100% plan

Georgia

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 HumanaOne health plans. A dependent child must be less than 26 years of age to apply.

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	Individual:	Family:	Individual:	Family:
Important to know: › Deductibles start over each new calendar 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 › Deductible carryover credit applies to the medical, mental health, and condition-specific deductibles, but does not apply to the prescription drug deductible › 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 5 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
	$10,000	$30,000	$30,000	$60,000
Coinsurance - The percentage of covered healthcare costs you have to pay while covered under this plan	Your 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	$0	$0	$5,000	$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	Unlimited			

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How your plan works

The details below give you a general idea of covered benefits for this plan and don't explain everything. To be covered, expenses must be medically necessary and listed as covered in the plan policy. The plan policy is a document which outlines the benefits, provisions, and limitations of the plan. Please refer to a policy for the actual terms and conditions of the plan. This plan also has limitations and services that are not covered. You should know about these. See page 5 for details.

	In-network	Out-of-network
Preventive care › Office visits, lab, child immunizations (age 5 to 18), flu and pneumonia (age 5 and older), X-ray, Pap smear, mammogram, prostate screening, and endoscopic services	Your plan pays 100%	You pay 30% after you pay your deductible
› Child wellness services, birth to age 5 (office visit, lab, immunizations, and flu/pneumonia)	Your plan pays 100%	You pay 30%
Diagnostic office visits	Your plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible
Diagnostic lab and X-rays - includes allergy testing	Your plan pays 100% after you pay your deductible	You pay 25% after you pay your deductible
Inpatient hospital and outpatient services	Your 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 pay 100% after you pay your deductible
Transplants	Your plan pays 100% after you pay your deductible when you receive services from a Humana Transplant Network provider	You pay 25% after you pay your deductible. Plan pays up to $35,000 per transplant

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How your plan works

	In-network	Out-of-network
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 › Covered expenses for mental health don't apply to the medical out-of-pocket maximum	You first pay your mental health deductible, which is the same amount as your in-network medical deductible Then, you pay 40%	You first pay your mental health deductible, which is the same amount as your out-of-network medical deductible Then, you pay 40%
Other medical services	Your 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 – up to 60 visits per calendar year • 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	
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, your plan pays** any remaining costs for out-of-network drugs

Add extra benefits to your medical plan

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

Make your HumanaOne 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 170,000 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. Visit **HumanaOneNetwork.com** to find participating dentists who offer discounts on these services.

Term life

HumanaOne 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: Your plan pays first $1,000 per accident at 100%, then plan benefits apply
- ☐ $2,500: Your plan pays first $2,500 per accident at 100%, then plan benefits apply
- ☐ $5,000: Your plan pays first $5,000 per accident at 100%, then plan benefits apply
- ☐ $10,000: Your plan pays first $10,000 per accident at 100%, then plan benefits apply

Mental disorder

If chosen, this extra benefit replaces the mental health benefit in your plan. Mental disorders includes coverage for Chemical and Alcohol Dependence.

- Day and visit maximums are for Mental Health, Chemical and Alcohol combined
- **Inpatient:** Up to 30 days per calendar year per covered person
- **Outpatient therapy:** Up to 48 visits per calendar year per covered person
- No waiting period
- Plan pays in-network and out-of-network, same as any other illness

Consumer Choice Option

If a provider you want to visit isn't in our network, you can nominate the provider. Providers must meet other criteria, so a nomination doesn't guarantee acceptance into our network. Additional premium charge may apply, depending on plan type.

To nominate a provider, fill out a Consumer Choice Option Provider Nomination Form and give it to the provider.

This form is available to you when you apply with us. Once the provider sends the completed form to us, we'll follow up with them and let you know the status of your nomination.

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 the policy. 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. The policy 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 or any complication of a pre-existing condition 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.

Limitations and exclusions (things that are not covered)

This is an outline of the limitations and exclusions for the HumanaOne individual health plan listed above. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. The policy is guaranteed renewable as long as premiums are paid. Other termination provisions apply as listed in the policy. 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 any 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 policy

Elective and cosmetic services

- Cosmetic services, or any related complication
- Elective medical or surgical procedures except elective tubal ligation and vasectomy
- Hair prosthesis, hair transplants, or hair implants
- Prophylactic services

Immunizations

- Immunizations except as stated in the policy

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury), appliances, or supplies
- Foot care services, except for the medically necessary treatment of diabetes
- Hearing care that is routine except as stated in the policy
- Vision examinations, except as stated in the policy, vision testing, eyeglasses or contact lenses

Pregnancy and sexuality services

- Pregnancy except for complications of pregnancy as defined in the policy. 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.
- Elective medical or surgical abortion except as stated in the policy
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- 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 policy
- 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 policy
- 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, unless otherwise stated in the policy
- Treatment of nicotine habit or addiction
- Any drug, medicine or device which is not FDA approved
- Contraceptives when prescribed for purposes others than to prevent pregnancy
- 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 bodily 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 drugs on the Women's Healthcare Drug List with a prescription and 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
- Over the counter medical items or supplies that are available without a prescription except for preventive services
- Brand name medication unless an equivalent generic medication is not available for drugs on the Women's Healthcare Drug List

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

This document contains a general summary of covered 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.

Your premium won't go up during the first year the policy 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.

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