GEORGIA

National POS

80/60 CoverageFirst Plan 11

The Purpose of This Benefit Summary

A benefit summary provides a brief overview of basic health plan features. For exact terms and conditions of your health plan benefits, please refer to your Benefit Plan Document, also known as your Certificate.

80/60 CoverageFirst Plan 11		If you use **IN-NETWORK** providers	If you use **OUT-OF-NETWORK** providers
Benefit Allowance	• Annual member benefit (Applies to medical services received from participating providers only. Preventive and pharmacy do not apply. Does not apply to member copayments.)	$500 per calendar/plan year per member	Not applicable
Annual Deductible	• Individual deductible	$250 $250 $500 $500 $1,000 $1,000 $1,500 $1,500 $2,000 $2,000 $2,500 $2,500 $3,000 $3,000 $4,000 $4,000 $5,000 $5,000	$500 $750 $1,000 $1,500 $2,000 $3,000 $3,000 $4,500 $4,000 $6,000 $5,000 $7,500 $6,000 $9,000 $8,000 $12,000 $10,000 $15,000
	• Family deductible[1]	$500 $500 $750 $750 $1,000 $1,000 $1,500 $1,500 $2,000 $2,000 $3,000 $3,000 $4,500 $4,500 $4,000	$1,000 $1,500 $1,500 $2,250 $2,000 $3,000 $3,000 $4,500 $4,000 $6,000 $6,000 $9,000 $9,000 $13,500 $8,000

80/60 CoverageFirst Plan 11		If you use **IN-NETWORK** providers	If you use **OUT-OF-NETWORK** providers
Annual Deductible *(continued)*		$4,000 $6,000 $6,000 $5,000 $5,000 $7,500 $7,500 $8,000 $8,000 $9,000 $9,000 $10,000 $10,000 $12,000 $12,000 $15,000 $15,000	$12,000 $12,000 $18,000 $10,000 $15,000 $15,000 $22,500 $16,000 $24,000 $18,000 $27,000 $20,000 $30,000 $24,000 $36,000 $30,000 $45,000
	The annual deductible is based upon a calendar/plan year. *Deductible and out-of-pocket limits for in-network and out-of-network providers calculate separately.*		
Maximum Out-of-Pocket Expense Limit	• Individual out-of-pocket maximum	$1,000 $1,000 $2,000 $2,000 $3,000 $3,000 $4,000 $4,000 $5,000 $5,000	$2,000 $3,000 $4,000 $6,000 $6,000 $9,000 $8,000 $12,000 $10,000 $15,000
	• Family out-of-pocket maximum	$2,000 $2,000 $3,000 $3,000 $4,000 $4,000 $6,000 $6,000 $9,000 $9,000 $8,000 $8,000 $12,000 $12,000 $10,000 $10,000 $15,000 $15,000	$4,000 $6,000 $6,000 $9,000 $8,000 $12,000 $12,000 $18,000 $18,000 $27,000 $16,000 $24,000 $24,000 $36,000 $20,000 $30,000 $30,000 $45,000
	The Maximum Out-of-Pocket Expense Limit is calculated on a calendar/plan year basis, and does not include copayments or deductibles.		

80/60 CoverageFirst Plan 11		Plan pays for services at **IN-NETWORK** providers	Plan pays for services at **OUT-OF-NETWORK** providers
Preventive Care *(birth through age five does not require deductible)*	• Preventive office visits (up to age 18)	**100%**	**70%** after deductible
	• Preventive immunizations (up to age 18)	**100%**	**70%** after deductible
	• Preventive office visit (18 years and above)	**100%**	**70%** after deductible
	• Preventive mammography	**100%**	**70%** after deductible
	• Preventive Pap Smears	**100%**	**70%** after deductible
	• Preventive outpatient laboratory tests	**100%**	**70%** after deductible
	• Preventive endoscopy	**100%**	**70%** after deductible
	• Preventive prostate screenings	**100%**	**70%** after deductible
	• Preventive flu/pneumonia immunization	**100%**	**70%** after deductible
Physician Services[2]	• Office visits (excludes diagnostic lab and X-ray)	**100%** after $20 primary care physician/$35 specialist $30 primary care physician/$45 specialist $40 primary care physician/$55 specialist $15 primary care physician/$45 specialist $25 primary care physician/$55 specialist $35 primary care physician/$75 specialist copayment per visit; **OR** $25 primary care physician/$25 specialist $35 primary care physician/$35 specialist copayment per visit	**70%** after deductible
	• Allergy testing (covered as part of office visit)	**100%**	**70%** after deductible
	• Physician visit to emergency room[4]	**100%**	**100%**
	• Diagnostic tests, lab and X-rays (when performed in an office or clinic)	**100%**	**70%** after deductible
	• Allergy serum	**100%**	**70%** after deductible
	• Inpatient/outpatient services	**80%** after deductible	**60%** after deductible
	• Allergy injections	**100%** after $5 copayment	**70%** after deductible
	• Physician surgery	**80%** after deductible	**60%** after deductible

80/60 CoverageFirst Plan 11		Plan pays for services at **IN-NETWORK** providers	Plan pays for services at **OUT-OF-NETWORK** providers
Facility Services	• Inpatient care (semiprivate room and board, nursing care, ICU)	**80%** after deductible	**60%** after deductible
	• Outpatient surgery	**80%** after deductible	**60%** after deductible
	• Outpatient nonsurgical care	**80%** after deductible	**60%** after deductible
	• Emergency room visit (copayment is waived if admitted)[4]	**100%** after $150 copayment **OR** **100%** after $250 copayment	**100%** after $150 copayment **OR** **100%** after $250 copayment
Other Medical Services[3]	• Skilled nursing facility (up to UNLIMITED, 60, 100 days per plan/ calendar year)	**80%** after deductible	**60%** after deductible
	• Home health care (up to UNLIMITED, 60, 100 visits per plan/calendar year)	**80%** after deductible	**60%** after deductible
	• Durable medical equipment	**80%** after deductible	**60%** after deductible
	• Physical, occupational, cognitive, speech and audiology therapy, spinal manipulations, adjustments, and modalities (up to 60, 30 visits per plan/ calendar year) Nonparticipating is limited to 10 of the 30 or 60 visits.	Same as specialist office visit	**70%** after deductible
	• Advanced imaging (PET, MRI, MRA, CAT, SPECT)	**80%** after deductible	**60%** after deductible
	• Advanced imaging in emergency room (PET, MRI, MRA, CAT, SPECT)[4]	**80%** after deductible	**80%** after in-network deductible
	• Ambulance[4]	**80%** after deductible	**80%** after in-network deductible
	• Urgent care	**100%** after $15/$20/ $25/$30/$35/$40 copayment at a Concentra facility $75/$100 copayment at a non-Concentra facility	**70%** after deductible
	• Retail clinics	Same as primary care office visit	**70%** after deductible
	• Maternity	Same as any other condition	Same as any other condition
Mental Health	• Inpatient services	**80%** after deductible	**60%** after deductible
	• Outpatient services	Same as specialist office visit	**70%** after deductible
Alcohol and Chemical Dependency	• Inpatient services	**80%** after deductible	**60%** after deductible
	• Outpatient services	Same as specialist office visit	**70%** after deductible

Prior authorization
Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at **Humana.com/members/tools** or call Customer Service.

Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

Payments
Participating 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 nonparticipating providers are based on maximum allowable fees, as defined in your Certificate of Insurance.

Nonparticipating 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.

Provider Disclaimer
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 judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

Primary care physicians are defined as family practitioner, general practitioner, pediatrician or internist.

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

Additional Coverage Information
Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. Limitations and exclusions to coverage apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing any procedure, treatment or supply. This guide is available at Humana.com/members/enrollment center/pre-enrollment disclosures or through your sales representative.

The amount of benefit provided depends upon the plan selected. Premiums will vary according to the selection made. For general questions about the plan, contact your benefits administrator.

(1) You are not required to meet individual deductibles once the family deductible has been met.

(2) The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician or internist.

(3) Visit and day limits are combined for participating and nonparticipating providers.

(4) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.

Pre-Existing Condition Exclusion
The plan imposes a pre-existing condition exclusion. If you have a medical condition before coming to our plan, you will be required to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy; genetic information in the absence of a diagnosis of the condition related to the information; or to a Covered Person who is under the age of 19.

This exclusion may last up to 6 months (18 months if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 90 days. To reduce the 6-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Humana Enrollment Department, P.O. Box 14330, Lexington, KY 40512-4330 or call 1-800-872-7207.

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