HumanaOpen Access Plus Summary of Benefits

GEORGIA	Open Access Plus Plan 90/70 1,000-20	Plan pays for services at *PARTICIPATING* providers	Plan pays for services at *NONPARTICIPATING* providers
Preventive Care	• Routine physical exams *(one per calendar year)* • Routine lab and X-rays • Well-child care *(to age 18)*	**100%** after a $20 primary care physician or $40 specialist copayment per visit	**70%** after deductible *(well-child care services age 0-5 do not require deductible)*
	• Immunizations • Flu and pneumonia shots	**100%**	**70%** after deductible
	• Routine Pap smear, mammogram and prostate screening • Prenatal benefit *(office visit copayment applies to first visit only)*	**100%** after a $20 primary care physician or $40 specialist copayment per visit	**70%** after deductible *(well-child care services age 0-5 do not require deductible)*
Physician Services	• Office visits • Diagnostic tests, lab and X-ray performed in office and billed by physician	**100%** after a $20 primary care physician or $40 specialist copayment per visit	**70%** after deductible *(well-child care services age 0-5 do not require deductible)*
	• Allergy testing, treatments and injections	**100%** after office visit copayment	**70%** after deductible
	• Allergy serum	**100%**	**70%** after deductible
	• Inpatient visits *(includes hospital and skilled nursing facility)* (1) • Outpatient visits *(includes surgery)*	**90%** after deductible	**70%** after deductible
	• Emergency room physician services (2)	**90%** after deductible	**90%** after participating deductible
	• Office surgery	**100%** after office visit copayment	**70%** after deductible
Hospital Services	• Inpatient care (1) • Diagnostic test, lab and X-ray • Outpatient nonsurgical • Outpatient surgical	**90%** after deductible	**70%** after deductible
	• Preadmission testing	**100%**	**70%** after deductible
	• Urgent care facility (2)	**100%** after a $50 copayment per visit	**100%** after a $50 copayment per visit
	• Emergency care *(emergency room)* (2)	**90%** after a $100 copayment per visit *(copayment waived if admitted)*	**90%** after a $100 copayment per visit *(copayment waived if admitted)*
Prescription Drugs	• See attached rider, if applicable.		
Other Medical Services	• Home health care *(up to 100 visits per calendar year)* • Skilled nursing facility *(maximum of 100 days per calendar year)* (1) • Durable medical equipment (1) • Hospice services (1) – Inpatient – Outpatient	**90%** after deductible	**70%** after deductible
	• Transplant services (1)	**90%** after deductible (3)	**70%** after deductible (4)
	• Occupational, physical, and speech therapy *(60 visits combined per calendar year)*	**100%** after a $40 copayment per visit	**70%** after deductible
Deductible	• Individual	$1,000	$2,000
	• Family	$3,000	$6,000
Out-of-Pocket Maximum	• Individual	$2,000	$4,000
	• Family	$4,000	$12,000

HumanaOpen Access Plus allows you to seek care from any provider without a referral. Care received from participating providers will be covered at a higher benefit level.

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GEORGIA Open Access Plus Plan 90/70 1,000-20		Plan pays for services at ***PARTICIPATING*** providers	Plan pays for services at ***NONPARTICIPATING*** providers
Lifetime Maximum		Unlimited	$2,000,000
Alcoholism, Chemical Dependency, Mental and Nervous Disorder Services	• Inpatient services *(limited to 15 days combined per calendar year)* (1)	**90%** after deductible	**70%** after deductible
	• Outpatient services *(limited to 20 visits combined per calendar year)*	**90%** after $40 copayment per visit	**70%** after deductible

Payments - Plan benefits are paid based on reasonable charges, as defined in your Certificate. Participating physicians agree to accept reasonable charges as paid in full.

For services rendered by nonparticipating providers, the member is responsible for amounts exceeding reasonable charges, as defined in your Certificate. Emergency services received while out of the service area, are covered at participating provider level.

Participating 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.

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

(1) Prior authorization is required in order to receive these benefits, and durable medical equipment over $750.

(2) Medically necessary emergency services received while out of the service area, are covered at participating level.

(3) All care must be approved and coordinated by Humana.

(4) Subject to a separate out-of-pocket maximum of $35,000 per calendar year.

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.

Limitations and Exclusions

This is a partial list of limitations and exclusions. Your group may have specific limitations and exclusions not included on this list. Please check your Group Contract/Certificate of Coverage for this complete listing. The Group Contract/Certificate of Coverage is the document upon which benefit payment will be determined.

Unless specifically stated otherwise, no services will be provided for the following items.

1. Care and treatment given in a hospital owned or run by any federal, state, or other government, unless the member is legally required to pay for such care and treatment. However, care and treatment provided by participating military hospitals to armed services retirees and their dependents are not excluded.
2. Any service the member would not be legally required to pay for in the absence of this coverage.
3. Sickness or injury for which the member is in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid.
4. Education or training; medical services provided by the member's parent, spouse, brother, sister or child.
5. Experimental or investigational drugs or substances not approved by us or by the Food and Drug Administration; drugs or substances used for other than Food and Drug Administration approved indications; or drugs labeled: "Caution-limited by Federal law to investigational use."
6. Drugs or medicines, prescription or nonprescription, (except diabetes supplies) provided to the member while he or she is not hospital confined, unless otherwise covered by a Prescription Drug Benefit Rider attached to the Group Plan. This exclusion does not apply to self-administered injectable drugs received by a member
   a. while an inpatient in a hospital or skilled nursing facility,
   b. from a physician during an office visit, or
   c. from a home health care agency approved by us.
7. Any service, supply or therapy to eliminate or reduce a dependency and/or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services and medications.
8. Any service, supply, care or treatment that is not described in this Health Services Agreement or any rider attached to and made a part of this Group Plan.
9. Eye refractions, the purchase or fitting of hearing aids, eyeglasses, contact lenses or advice on their care, except the first pair of eyeglasses or contacts needed due to: cataract surgery; or an accident that occurs while covered under the Group Plan, if eyeglasses or contacts were not needed prior to the accident, unless otherwise covered by a Vision Care Rider attached to the Group Plan.
10. Any drug, biological product, device, medical treatment, or procedure which is experimental or investigational that is defined in this Group Plan; any drug, biological procedure, device, medical treatment or procedure which is not covered as experimental or investigational (or similar) by the HCFA Medicare Coverage Issues Manual; any drug, biological product, or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which lacks such approval at the time of its use or proposed use; or, any drug or biological product categorized as a Treatment Investigation New Drug (IND) by the U.S. Food and Drug Administration or as a Group C Treatment Protocol drug by the U.S. National Cancer Institute at the time of its use or proposed use.
11. No services will be provided for plastic, cosmetic or reconstructive surgery unless a functional impairment is present. An objective functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. The presence of a psychological condition will not entitle a member to coverage for plastic, cosmetic or reconstructive surgery unless all conditions are met. Coverage will be extended for breast reconstruction when the member has had a medically necessary mastectomy, as determined by Us.
12. Services and supplies for dental care including braces and dental appliances, treatment of the teeth or periodontium or oral surgery, unless the services
    a. are required due to the surgical removal of a tumor or lesion in the mouth, or
    b. are received in connection with an injury to sound natural teeth or jaw sustained while the member is covered under the Group Plan if
       1. the care and treatment is provided within 12 months from the date of the injury,
       2. the member is continuously covered under the Group Plan from the date of the injury to the date the care and treatment are received, and
       3. the injury was not the result of biting or chewing. We will not cover dental implants or any treatment related to the preparation or fitting of dentures.
13. A physical examination given:
    a. to obtain or continue employment, insurance or government licensure,
    b. for or in connection with school or camp. However, this limitation will not apply if services are provided by the member's participating physician as part of covered preventive services otherwise provided by the Group Plan.
14. Any care, treatment, services or supplies received outside of the service area:
    a. if the member could have reasonably foreseen or anticipated their need prior to departure from the service area, and
    b. which are not authorized by Us as described in the Schedule of Emergency Coverage by Nonparticipating Providers or to the extent they exceed reasonable charges or unless otherwise covered under the Group Plan.
15. Sickness or injury for which the member refuses to accept the recommended care and treatment of his or her physician when:
    a. the physician believes that no professionally acceptable alternative exists; and
    b. we have given the member written notice that we will only provide the physician's recommended care and treatment. The member has the right to appeal a decision of this nature by using the Grievance Procedure as outlined in the Group Plan.
16. Any surgical procedure to reduce obesity, unless qualified as morbid obesity and medically necessary.

Limitations and Exclusions *(continued)*

17. Elective abortion unless:
    a. the physician certifies in writing that the pregnancy would endanger the life of the mother; or
    b. the services are received to treat medical complications due to the abortion.
18. Spinal manipulations and subluxations, unless medically necessary.
19. Any expense incurred before or after the date of the member's coverage under this Group Plan.
20. Any and all services related to organ or artificial organ transplants or organ donations, except as specifically provided in the Transplant Services (Organ) subsection of this Group Plan.
21. Care and treatment rendered by a provider whose services are not required to be covered by state law, except as provided by the Group Plan.
22. Care and treatment of complications of noncovered procedures, unless required by state law.
23. Treatment of any injury or sickness that is sustained by a subscriber or a covered dependent that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the subscriber or covered dependent. This exclusion does not apply to the following employees of the employer that are or may be eligible for coverage under any Workers' Compensation Act or similar law when the employer is given the option to apply for such coverage by such Act or law and the employer did not apply for such coverage; provided 24-hour medical coverage was selected by the employer on the Group Application, and which application was approved by us, and the required additional premium was paid to us:
    a. sole proprietor, if the employer is a proprietorship;
    b. a partner of the employer, if the employer is a partnership;
    c. an executive officer of the employer, if the employer is a corporation.

Offered by Humana Employers Health Plan of Georgia, Inc.