HUMANA EMPLOYERS HEALTH PLAN OF GA/HUMANA INS CO: CR NPOS 17-SEP ACC&CPY OV, IP, OP

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 01/01/2017
Coverage For: Individual + Family | **Plan Type:** NPOS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.humana.com** or by calling www.humana.com or by calling 1-866-4ASSIST (427-7478) .

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$0 Individual / $0 Family** Non-Network: **$5,000 Individual / $10,000 Family** Doesn't apply to prescription drugs and network preventive services. Co-insurance and co-payments don't count toward the deductible	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses	Yes. For Network providers **$6,000 Individual / $12,000 Family** For Non-Network providers **$18,000 Individual / $36,000 Family**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance-billed charges, Health care this plan doesn't cover, Penalties, Non-network transplant, non-network prescription drugs, non-network specialty drugs	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.humana.com or call 1-866-4ASSIST (427-7478)** for a list of Network providers. For Prescription Drugs: National Rx Network	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call www.humana.com or by calling 1-866-4ASSIST (427-7478) or visit us at **www.humana.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call www.humana.com or by calling 1-866-4ASSIST (427-7478) to request a copy.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay/visit	30% coinsurance	----------none----------
	Specialist visit	$90 copay/visit	30% coinsurance	----------none----------
	Other practitioner office visit	Chiropractor Exam: No charge after deductible	Chiropractor Exam: 30% coinsurance	----------none----------
	Preventive care / screening / immunization	No charge	30% coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	$425 copay	30% coinsurance	Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 40%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.humana.com/2017-Rx4-EHB.** Click here	Level 1 - Lowest cost generic and brand-name drugs	$10 copay (Retail) $25 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order) Non-network cost sharing does not count toward the out-of-pocket limit.
	Level 2 - Higher cost generic and brand-name drugs	$35 copay (Retail) $87.5 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	$65 copay (Retail) $162.5 copay (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Specialty drugs	35% coinsurance	35% coinsurance	25% coinsurance when filled via a preferred network specialty pharmacy Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1750 copay/visit	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	No charge	30% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	$425 copay/visit	$425 copay/visit	Copayment waived if admitted
	Emergency medical transportation	$425 copay/transport	$425 copay/transport	----------none----------
	Urgent care	$125 copay/visit	30% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$1750 copay/day	30% coinsurance	3 days for copay per day Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fee	No charge	30% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 copay/visit	30% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	$1750 copay/day	30% coinsurance	3 days for copay per day Preauthorization may be required - if not obtained, penalty will be 40%
	Substance use disorder outpatient services	$45 copay/visit	30% coinsurance	----------none----------
	Substance use disorder inpatient services	$1750 copay/day	30% coinsurance	3 days for copay per day Preauthorization may be required - if not obtained, penalty will be 40%
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	----------none----------
	Delivery and all inpatient services	$1750 copay/day	30% coinsurance	3 days for copay per day Preauthorization may be required - if not obtained, penalty will be 40%
If you need help recovering or have other special health needs	Home health care	$90 copay/visit	30% coinsurance	120 visits per year Preauthorization may be required - if not obtained, penalty will be 40%
	Rehabilitation services		30% coinsurance	Therapies:

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		Rehabilitation: No charge after deductible Therapies: $90 copay/visit		Preauthorization may be required - if not obtained, penalty will be 40% Manipulations and Therapies: 40 Visits per year combined with Physical Therapy/ Occupational Therapy/ Speech Therapy/ Audiology Therapy include Adjus & Manip, exclude Cognitive Therapy 40 visits per year combined with Physical Therapy/ Occupational Therapy/ Audiology Therapy/ Speech Therapy/ Cognitive Therapy include Adjus & Manip For non-network, 10 Visits per year combined with Physical Therapy/ Occupational Therapy/ Speech Therapy/ Audiology Therapy include Adjus & Manip, exclude Cognitive Therapy For non-network, 10 visits per year combined with Physical Therapy/ Occupational Therapy/ Audiology Therapy/ Speech Therapy/ Cognitive Therapy include Adjus & Manip
	Habilitation services	Habilitation: No charge after deductible Therapies: $90 copay/visit	30% coinsurance	
	Skilled nursing care	$90 copay/day	30% coinsurance	60 day limit per year Preauthorization may be required - if not obtained, penalty will be 40%
	Durable medical equipment	No charge	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40% for durable medical equipment $750 and over Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice service	No charge	30% coinsurance	----------none----------
If your child needs dental or eye care	Eye exam	$10 copay/visit	50% coinsurance	1 exam per year until the end of the month child turns 19
	Glasses	40% coinsurance	40% coinsurance	1 pair of frames per year until end of month child turns 19 1 pair of lenses per year until end of month child turns 19
	Dental check-up	40% coinsurance	40% coinsurance	2 exams per year until end of the month child turns 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emegency care when traveling outside of the U.S
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care - spinal manipulations are covered

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:
Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478)
Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/esba/healthreform
Georgia Office of Insurance and Safety Fire Commissioner, Two Martin Luther King Jr. Drive, West Tower, Suite 704, Atlanta, GA 30334, Phone: 404-656-2056 or 800-656-2298 (toll free)

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,940
- **Patient pays:** $2,600

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$2,600
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,600**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,580
- **Patient pays:** $1,820

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,800
Coinsurance	$0
Limits or exclusions	$20
Total	**$1,820**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call www.humana.com or by calling 1-866-4ASSIST (427-7478) or visit us at **www.humana.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call www.humana.com or by calling 1-866-4ASSIST (427-7478) to request a copy.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-866-427-7478 or send an email to accessibility@humana.com, or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-866-427-7478 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-866-427-7478 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-427-7478 (TTY: 711)**.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-866-427-7478 (TTY: 711)**。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-866-427-7478 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-866-427-7478 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-427-7478 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-866-427-7478 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-427-7478 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-866-427-7478 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-866-427-7478 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-866-427-7478 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-866-427-7478 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-866-427-7478 (TTY: 711)**.

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 **1-866-427-7478 (TTY：711)** まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-866-427-7478 (TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-866-427-7478 (TTY: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-427-7478 (رقم هاتف الصم والبكم: 711)**.