



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.groupcertificate.humana.com or by calling 1-866-4ASSIST (427-7478). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$0 Individual / \$0 family; Non-Network: \$5,000 Individual / \$10,000 family <u>Coinsurance</u> doesn't count toward the deductible	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	<u>Network Providers</u> : Not Applicable. <u>Non-Network Providers</u> : Yes. <u>Emergency Room Care</u> and <u>Prescription Drugs</u> .	This plan does not have a network <u>deductible</u> . This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> \$4,500 individual / \$9,000 family; For non-network <u>providers</u> \$13,500 individual / \$27,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>Balance-billing</u> charges, Health care this plan doesn't cover, Penalties, Non-network transplant, non-network <u>prescription drugs</u> , non-network <u>specialty drugs</u>	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <u>network provider</u>?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of <u>network providers</u> For Prescription Drugs: National Rx Network	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 copay/office visit	30% <u>coinsurance</u>	Telehealth or telemedicine services:
	<u>Specialist</u> visit	\$75 copay/visit	30% <u>coinsurance</u>	Telehealth or telemedicine services:
	<u>Preventive care</u> / <u>screening</u> / immunization	Preventive Care: No charge Immunization: No charge	Preventive Care: 30% <u>coinsurance</u> ; <u>deductible</u> does not apply Immunization: 30% <u>coinsurance</u> ; <u>deductible</u> does not apply	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	<u>Diagnostic Test</u> : <u>Cost share</u> may vary based on where service is performed <u>Imaging</u> : <u>Cost share</u> may vary based on where service is performed <u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	Imaging (CT/PET scans, MRIs)	\$350 copay	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.humana.com/2018-Rx4-EHB	Level 1 - Lowest cost generic and brand-name drugs	\$10 <u>copay</u> (Retail); <u>deductible</u> does not apply \$25 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	No charge, after <u>network copay</u> (Retail); <u>deductible</u> does not apply No charge, after <u>network copay</u> (Mail Order); <u>deductible</u> does not apply	30 day supply <u>Preauthorization</u> may be required - if not obtained, penalty will be 100% for certain <u>prescription drugs</u> (Retail) 90 day supply <u>Preauthorization</u> may be required - if not obtained, penalty will be 100% for certain <u>prescription drugs</u> (Mail Order) Non-network <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .
	Level 2 - Higher cost generic and brand-name drugs	\$35 <u>copay</u> (Retail); <u>deductible</u> does not apply \$87.50 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	No charge, after <u>network copay</u> (Retail); <u>deductible</u> does not apply No charge, after <u>network copay</u> (Mail Order); <u>deductible</u> does not apply	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	\$55 <u>copay</u> (Retail); <u>deductible</u> does not apply \$137.50 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	No charge, after <u>network copay</u> (Retail); <u>deductible</u> does not apply No charge, after <u>network copay</u> (Mail Order); <u>deductible</u> does not apply	
	Level 4 - Highest cost drugs	25% <u>coinsurance</u> (Retail); <u>deductible</u> does not apply 25% <u>coinsurance</u> (Mail Order); <u>deductible</u> does not apply	No charge, after <u>network copay</u> (Retail); <u>deductible</u> does not apply No charge, after <u>network copay</u> (Mail Order); <u>deductible</u> does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Specialty Drugs</u>	35% <u>coinsurance</u> ; <u>deductible</u> does not apply 25% <u>coinsurance</u> (Preferred Specialty Pharmacy); <u>deductible</u> does not apply	35% <u>coinsurance</u> ; <u>deductible</u> does not apply 35% <u>coinsurance</u> (Preferred Specialty Pharmacy); <u>deductible</u> does not apply	30 day supply <u>Preauthorization</u> may be required - if not obtained, penalty will be 100% for certain <u>prescription drugs</u>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$750 copay/visit	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$350 copay/visit	\$350 copay/visit; <u>deductible</u> does not apply	<u>Emergency room care</u> : <u>Copayment</u> waived if admitted
	<u>Emergency medical transportation</u>	\$350 copay/transport	\$350 copay/transport; <u>deductible</u> does not apply	
	<u>Urgent care</u>	\$100 copay/visit	30% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 copay/day	30% <u>coinsurance</u>	3 days for <u>copay</u> per day <u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay/visit	30% <u>coinsurance</u>	Inpatient services: 3 days for <u>copay</u> per day <u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	Inpatient services	\$750 copay/day	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	<p>Office visits: <u>Cost sharing</u> does not apply for <u>preventive services</u>.</p> <p>Childbirth/delivery professional services: Depending on the type of services, a <u>deductible</u> may apply.</p> <p>Childbirth/delivery facility services: Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) 3 days for <u>copay</u> per day <u>Preauthorization</u> may be required - if not obtained, penalty will be 40%</p>
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services.	\$750 copay/day	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$75 copay/visit	30% <u>coinsurance</u>	120 visit limit per year <u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	<u>Rehabilitation services</u>	Physical, occupational, speech, cognitive, audiology therapy and manipulations: \$40 copay/visit	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 30% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 40% REHABILITATION Physical, occupational, speech, cognitive, audiology therapy and manipulations: 40 visits per year combined with PT/OT/AT/ST/CT include Adjus & Manips HABILITATION Physical, occupational, speech, cognitive, audiology therapy and manipulations: 40 Visits per year combined with PT/OT/ST/AT include Adjus & Manip, exclude CT
	<u>Habilitation services</u>	Physical, occupational, speech, cognitive, audiology therapy and manipulations: \$40 copay/visit	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 30% coinsurance	
	<u>Skilled nursing care</u>	\$75 copay/day	30% coinsurance	60 day limit per year Preauthorization may be required - if not obtained, penalty will be 40%
	<u>Durable medical equipment</u>	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 modificationsexercise and bathroom equipment

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Hospice services</u>	No charge	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
If your child needs dental or eye care	Children's eye exam	\$10 copay/visit	30% coinsurance	Plan coverage limited to 1 exam per year until the end of the month child turns 19
	Children's glasses	40% coinsurance	40% coinsurance	Plan coverage limited to 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
	Children's 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Bariatric Surgery • Infertility Treatment • Long Term Care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private Duty Nursing • Routine eye care (Adult) 	<ul style="list-style-type: none"> • Routine Foot Care • Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture, if it is prescribed by a physician • Chiropractic Care - spinal manipulations are covered 	<ul style="list-style-type: none"> • Cosmetic Surgery, if to correct a functional impairment • Dental Care (Adult), if for dental injury of a sound natural tooth 	<ul style="list-style-type: none"> • Hearing Aids, 1 aid per ear per 48 rolling months

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- Humana at 1-866-4ASSIST (427-7478).
 - For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
 - For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
 - If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.
- Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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/ebsa/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 plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$75
■ Hospital (facility) <u>copayment</u>	\$750
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
--------------------	----------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$1,500

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$75
■ Hospital (facility) <u>copayment</u>	\$750
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
--------------------	---------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$75
■ Hospital (facility) <u>copayment</u>	\$750
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$40
The total Mia would pay is	\$1,440

The plan would be responsible for the other costs of these EXAMPLE covered services.

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, 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'déé', t'áá jiik'eh, éí ná hóló, kójj' 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)**.