



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 1-800-833-6917.

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 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 For Non-Network providers \$19,050 Individual / \$38,100 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, Out-of-network Co-Insurance	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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.humana.com or call 1-800-833-6917 for a list of Network providers.	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 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 .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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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 1-800-833-6917 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .
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- **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	\$50 copay/visit	30% coinsurance	n o n e
	Specialist visit	\$100 copay/visit	30% coinsurance	n o n e
	Other practitioner office visit	Chiropractor Exam: \$100 copay/visit	Chiropractor Exam: 30% coinsurance	n o n e
	Preventive care / screening / immunization	No charge	30% coinsurance	limited coverage for preventive care
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)	\$600 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 <u>prescription drug coverage</u> is available at www.humana.com.	Level 1 - Lowest cost generic and brand-name drugs	\$10 copay (Retail) \$25 copay (Mail Order)	No charge after deductible (Retail) No charge (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)
	Level 2 - Higher cost generic and brand-name drugs	\$40 copay (Retail) \$100 copay (Mail Order)	No charge after deductible (Retail) No charge (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	\$70 copay (Retail) \$175 copay (Mail Order)	No charge after deductible (Retail) No charge (Mail Order)	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	No charge after deductible (Retail) No charge (Mail Order)	
	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)	\$1500 copay/visit	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	No charge	30% coinsurance	n o n e
If you need immediate medical attention	Emergency room services	\$600 copay/visit	\$600 copay/visit	Copayment waived if admitted
	Emergency medical transportation	\$600 copay/transport	\$600 copay/transport	n o n e
	Urgent care	\$125 copay/visit	30% coinsurance	n o n e

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 have a hospital stay	Facility fee (e.g., hospital room)	\$1500 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	n o n e
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$50 copay/visit	30% coinsurance	n o n e
	Mental/Behavioral health inpatient services	\$1500 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	\$50 copay/visit	30% coinsurance	n o n e
	Substance use disorder inpatient services	\$1500 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	n o n e
	Delivery and all inpatient services	\$1500 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	\$100 copay/visit	30% coinsurance	120 visit limit per calendar year Preauthorization may be required - if not obtained, penalty will be 40%
	Rehabilitation services	\$100 copay/visit	30% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 40% Manipulations and Therapies: 40 visits per cal yr, includes manipulations, adjustments For non-network, 10 visit per cal yr, includes manipulations, adjustments
	Habilitation services	\$100 copay/visit	30% coinsurance	
	Skilled nursing care	\$100 copay/day	30% coinsurance	60 days per calendar year 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
	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
	Hospice service	No charge	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
If your child needs dental or eye care	Eye exam	40% coinsurance	40% coinsurance	1 exam every 12 months
	Glasses	40% coinsurance	40% coinsurance	1 frame every 12 months 1 Pair of lenses per 12 months
	Dental check-up	40% coinsurance	40% coinsurance	Two every year up to age 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.)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Hearing Aids 	<ul style="list-style-type: none"> Long-term care Non Emergent Care Private Duty Nursing 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Chiropractic care - spinal manipulations are covered 	<ul style="list-style-type: none"> Infertility treatment 	

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-833-6917. You may also contact your state insurance department at 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).

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:

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 provide minimum essential coverage for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-833-6917

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)

- n Amount owed to providers: \$7,540
- n Plan pays \$5,140
- n Patient pays \$2,400

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	\$2,400
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$2,400

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

- n Amount owed to providers: \$5,400
- n Plan pays \$3,480
- n Patient pays \$1,920

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	\$1,900
Coinsurance	\$0
Limits or exclusions	\$20
Total	\$1,920

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 network **providers**. If the patient had received care from non-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?

ü 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?

ü 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?

ü 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?

ü 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.

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