

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, visit 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: \$4,000 Individual / \$8,000 family; Non-Network: \$12,000 Individual / \$24,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , 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> : Yes. Preventive <u>Non-Network Providers</u> : No.	This <u>plan</u> 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 <u>plan</u> 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> \$4,000 individual / \$8,000 family For non-network <u>providers</u> \$14,500 individual / \$29,000 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 <u>plan</u> , 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?	Premiums, <u>Balance-billing</u> charges, Health care this <u>plan</u> 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 network provider?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of <u>network providers</u> .	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 charge</u> 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	Telehealth or telemedicine services: No charge after <u>deductible</u> Primary care visit: No charge after <u>deductible</u>	Telehealth or telemedicine services: 30% <u>coinsurance</u> Primary care visit: 30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. 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 after <u>deductible</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> may vary based on where service is performed. Imaging: <u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	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 prescription drug coverage is available at https://www.humana.com/2021-HDHPT	Generic and brand-name drugs	No charge after <u>deductible</u> (Retail) (Mail Order) No charge after <u>deductible</u>	(Retail) No charge after <u>deductible</u> (Mail Order) No charge after <u>deductible</u>	(Retail) 30 day supply <u>Preauthorization</u> may be required - if not obtained, member is responsible for 100% of the cost of the drug (Mail) 90 day supply <u>Preauthorization</u> may be required - if not obtained, member is responsible for 100% of the cost of the drug
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after <u>deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	
	<u>Urgent care</u>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	Inpatient services	No charge after <u>deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</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)	
	Childbirth/delivery professional services	No charge after <u>deductible</u>	30% <u>coinsurance</u>	Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery facility services.	No charge after <u>deductible</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	100 visits 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: No charge after <u>deductible</u>	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 30% <u>coinsurance</u>	Therapies: <u>Preauthorization</u> may be required - if not obtained, penalty will be 40% Physical, occupational, speech, cognitive, audiology therapy and manipulations: For <u>network</u> , 60 visits per year combined For non-network, 10 visits per year combined. <u>Network</u> and non-network visit limits reduce each other.
	<u>Habilitation services</u>	Physical, occupational, speech, audiology therapy and manipulations: No charge after <u>deductible</u>	Physical, occupational, speech, audiology therapy and manipulations: 30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	60 day limit per year <u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
	<u>Durable medical equipment</u>	No charge after <u>deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 40% Excludes vehicle and home modifications, exercise, 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 after <u>deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 40%
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)		
<ul style="list-style-type: none"> • Bariatric surgery • Child dental check-up • Child eye exam • Child glasses 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside of the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan 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, \$3000.00 per hearing aid to age 19; 1 aid per ear per 48 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:

- www.humana.com or 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 on how 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:

- 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: 1-800-656-2298 or www.oci.ga.gov.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478) (TTY: 711).

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

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 deductible	\$4,000
Specialist copayment	\$0
Hospital (facility) coinsurance	0%
Other coinsurance	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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$4,020

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	\$4,000
Specialist copayment	\$0
Hospital (facility) coinsurance	0%
Other coinsurance	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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

Mia's Simple Fracture

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

The plan's overall deductible	\$4,000
Specialist copayment	\$0
Hospital (facility) coinsurance	0%
Other coinsurance	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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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

