HUMANA EMPLOYERS HEALTH PLAN OF GA/HUMANA INS CO: CR NPOS 16-SEP ACC&CPY OV&DED/COINS IP/OP

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

Coverage Period: Beginning on or after 09/01/2016
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 1-866-4ASSIST (427-7478).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$1,500 Individual / $3,000 Family** Non-Network: **$4,500 Individual / $9,000 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?	Prescription drug coverage Network: **$100 Individual / $200 Family** Non-Network: **$100 Individual / $200 Family**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
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, 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 *specific* covered services, such as office visits.

Questions: Call 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 1-866-4ASSIST (427-7478) to request a copy.

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**.
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 5. 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	$40 copay/visit	30% coinsurance	----------none----------
	Specialist visit	$75 copay/visit	30% coinsurance	----------none----------
	Other practitioner office visit	Chiropractor Exam: $75 copay/visit	Chiropractor Exam: 30% coinsurance	----------none----------
	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 after deductible	30% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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.** **Click here**	Level 1 - Lowest cost generic and brand-name drugs	$10 copay (Retail) $25 copay (Mail Order)	No charge, after Network copay (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	$45 copay (Retail) $112.50 copay (Mail Order)	No charge, after Network copay (Retail) No charge (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	$75 copay (Retail) $187.50 copay (Mail Order)	No charge, after Network copay (Retail) No charge (Mail Order)	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	No charge, after Network copay (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)	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	$500 copay/visit	$500 copay/visit	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------none----------
	Urgent care	$100 copay/visit	30% coinsurance	----------none----------

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)	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fee	20% coinsurance	40% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/visit	30% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Substance use disorder outpatient services	$40 copay/visit	30% coinsurance	----------none----------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	----------none----------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	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	20% coinsurance	40% coinsurance	120 visit limit per calendar year Preauthorization may be required - if not obtained, penalty will be 40%
	Rehabilitation services	$75 copay/visit	30% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 40% Manipulations and Therapies: 40 visits per calendar year includes manipulations, adjustments For non-network, 10 visit per calendar year includes manipulations, adjustments
	Habilitation services	$75 copay/visit	30% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 day limit per calendar year Preauthorization may be required - if not obtained, penalty will be 40%
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40% for durable medical equipment $750 and over
	Hospice service	20% coinsurance	40% coinsurance	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 your child needs dental or eye care	Eye exam	$10 copay/visit	30% 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 Emergent Care received from foreign providers
- 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/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 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:** $5,000
- **Patient pays:** $2,540

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	$1,500
Copays	$40
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$2,540**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,480
- **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	$100
Copays	$1,800
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?

✘ **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.