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** Does not 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: **$200 individual / $400 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. Does not apply to tier 1 drugs.
Is there an out–of–pocket limit on my expenses?	Yes. For Network Providers **$5,000 Individual / $13,000 Family** For Non – Network Providers **$15,000 Individual / $39,000 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, Healthcare this plan doesn't cover, Penalties, Non-Network transplant	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

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can review 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 – This plan uses the Humana Choice POS network. See **www.humana.com** for a list of PAR providers.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-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.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. 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 **PAR 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	50% coinsurance	———none———
	Specialist visit	$50 copay / visit	50% coinsurance	———none———
	Other practitioner office visit (chiropractor)	20% coinsurance	50% 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
	Preventive care/screening/ Immunization / endoscopic / preventive care (child) / screening (child) / immunizations (child)	No charge	50% coinsurance	Limited coverage for preventive care
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Cost share may vary based on where service is performed. Preauthorization may be required – if not obtained, the penalty may be 50%
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com	Level 1 – Lowest cost generic and brand name drugs	$10 copay (Retail) $20 copay (Mail Order)	50% coinsurance (Retail) 50% coinsurance (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) $90 copay (Mail Order)	See Level 1 for Non-Network benefit	See Level 1 for Limitations and Exceptions
	Level 3 – Generic and brand-name drugs with higher cost than Level 2	$65 copay (Retail) $130 copay (Mail Order)	See Level 1 for Non-Network benefit	See Level 1 for Limitations and Exceptions

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:	$100 copay	50% coinsurance	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	50% coinsurance	Preauthorization may be required – if not obtained, penalty will be 50%
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	———none———
If you need immediate medical attention	Emergency room services	$250 copay Per visit	$250 copay Per visit	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	———none———
	Urgent care	$50/copay	50% coinsurance	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization may be required – if not obtained, penalty will be 50%
	Physician/ surgeon fee	20% coinsurance	50% coinsurance	———none———
If you have mental health, behavioral health, or substance abuse needs	Mental/ Behavioral health outpatient services	$40 copay/visit	50% coinsurance	———none———
	Mental/ Behavioral health inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required – if not obtained, penalty will be 50%
	Substance use disorder outpatient services	$40 copay/visit	50% coinsurance	———none———
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required – if not obtained, penalty will be 50%

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 are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	———none———
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required – if not obtained, penalty will be 50%
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visit limit per calendar year Preauthorization may be required – if not obtained, penalty will be 50%
	Rehabilitation and Habilitation	20% coinsurance	50% coinsurance	Therapy limited to 60 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Skilled nursing care	20% coinsurance	50% coinsurance	60 day limit per cal yr/ plan yr Preauthorization may be required - if not obtained, Penalty will be 50%
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization may be required – if not obtained, penalty will be 50%
	Hospice service	20% coinsurance	50% coinsurance	Preauthorization may be required – if not obtained, penalty will be 50%
If your child needs dental or eye care	Eye exam	Not Covered	Not covered	———none———
	Glasses	Not covered	Not covered	———none———
	Dental check-up	Not covered	Not covered	———none———

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
- Routine eye care (Adult)
- Routine foot care
- Infertility treatment
- Non emergent care received from foreign providers
- Private Duty Nursing
- 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
- Hearing Aids for children under 18

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. 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.
Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Commerce and Insurance, 500 James Robertson Parkway, Davy Crockett Tower, Nashville, TN 37243-0565, Phone: 615-741-2241
Additionally, a consumer assistance program can help you file your appeal. Contact Tennessee Department of Commerce and Insurance at: 500 James Robertson Parkway, Davy Crockett Tower, 4th Floor, Nashville, TN 37243-0565, Website: www.tn.gov/commerce/insurance, Email: CIS.Complaints@state.tn.us, Phone 800-342-4029

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	$200
Copays	$1,700
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 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.

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