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 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 866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $1,500 individual / $3,000 family; Non-Network Providers: $4,500 individual / $9,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Network Providers: Yes. Certain Office Visits, Preventive Care, Emergency Room Care, Urgent Care, Prescription Drugs and Certain Therapies Non-Network Providers: Yes. Emergency Room Care and Prescription Drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $6,500 individual / $13,000 family; For non-network providers: $19,500 individual / $39,000 family	The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services, non-network transplant, non-network prescription drugs, non-network specialty drugs, non-network immune effector cell therapy.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.humana.com/directories or call 866-4ASSIST (427-7478) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Telehealth or telemedicine services: $30 copay/office visit; deductible does not apply Primary care visit: $30 copay/office visit; deductible does not apply	Telehealth or telemedicine services: 50% coinsurance Primary care visit: 50% coinsurance	None
	Specialist visit	$55 copay/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

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 have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	50% coinsurance	Cost sharing may vary based on where service is performed. Imaging: Preauthorization may be required - if not obtained, penalty will be 50%.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.humana.com/2023-Rx4/	Level 1 - Low-cost generic and brand-name drugs	(Retail) $10 copay/prescription; deductible does not apply (Mail Order) $25 copay/prescription; deductible does not apply	(Retail) 30% coinsurance, after $10 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $25 copay/prescription; deductible does not apply	(Retail) 30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug. (Mail Order) 90 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug.
	Level 2 - Higher-cost generic and brand-name drugs	(Retail) $35 copay/prescription; deductible does not apply (Mail Order) $87.50 copay/prescription; deductible does not apply	(Retail) 30% coinsurance, after $35 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $87.50 copay/prescription; deductible does not apply	
	Level 3 - High-cost, mostly brand-name drugs	(Retail) $55 copay/prescription; deductible does not apply (Mail Order) $137.50 copay/prescription; deductible does not apply	(Retail) 30% coinsurance, after $55 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $137.50 copay/prescription; deductible 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)	
	Level 4 - Highest-cost drugs	(Retail) 25% coinsurance; deductible does not apply (Mail Order) 25% coinsurance; deductible does not apply	(Retail) 30% coinsurance, after 25% coinsurance; deductible does not apply (Mail Order) 30% coinsurance, after 25% coinsurance; deductible does not apply	
	Specialty drugs	Preferred network specialty pharmacy: 25% coinsurance; deductible does not apply Network specialty pharmacy: 35% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	30 day supply. Preauthorization 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)	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 care	$150 copay/visit; deductible does not apply	$150 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance after network deductible	
	Urgent care	$75 copay/visit; deductible does not apply	50% coinsurance	
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 fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $30 copay/visit; deductible does not apply Outpatient hospital non-surgical services: 20% coinsurance	Therapy: 50% coinsurance Outpatient hospital non-surgical services: 50% coinsurance	None

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)	
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
If you are pregnant	Office visits	No charge; deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	100 visits per year. Preauthorization may be required - if not obtained, penalty will be 50%.
	Rehabilitation services	Physical, occupational therapy and manipulations: $30 copay/visit; deductible does not apply Speech, cognitive and audiology therapy: $55 copay/visit; deductible does not apply	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 50% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50%. Physical, occupational, speech, cognitive, audiology therapy and manipulations: For network, 60 visits per year combined. For non-network, 10 visits per year combined. Network and non-network visit limits reduce each other.

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)	
	Habilitation services	Physical, occupational therapy and manipulations: $30 copay/visit; deductible does not apply Speech and audiology therapy: $55 copay/visit; deductible does not apply	Physical, occupational, speech, audiology therapy and manipulations: 50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	60 day limit per year. 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%. Excludes vehicle and home modifications,exercise and bathroom equipment.
	Hospice services	No charge; deductible does not apply	No charge; deductible does not apply	Preauthorization may be required - if not obtained, penalty will be 50%.
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 any other excluded services.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)		
• Acupuncture (if it is prescribed by a physician)	• Cosmetic surgery (if to correct a functional impairment)	• Hearing aids (1 hearing aid per impaired ear every 36 months under the age of 18)
• Chiropractic care - spinal manipulations are covered	• Dental care (Adult) (if for dental injury of a sound natural tooth)	

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 866-4ASSIST (427-7478).
- Kentucky Department of Insurance: 800-595-6053 or https://insurance.ky.gov/ppc/CHAPTER.aspx.
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 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 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 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 866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Kentucky Department of Insurance: 800-595-6053 or https://insurance.ky.gov/ppc/CHAPTER.aspx.

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 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	$1,500
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,470**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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:

Cost Sharing	
Deductibles	$1,200
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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