




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:
<p>What is the overall deductible?</p>	<p><u>Network</u>: \$1,500 individual / \$3,000 family; <u>Non-Network</u>: \$4,500 individual / \$9,000 family \$500.00 <u>Network benefit allowance</u> applies before <u>deductible</u>. Does not apply to any member <u>copayments</u>, Rx, or <u>preventive care</u>.</p>	<p>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>.</p>
<p>Are there services covered before you meet your deductible?</p>	<p><u>Network Providers</u>: Yes. Certain <u>Office Visits</u>, <u>Preventive Care</u>, <u>Emergency Room Care</u>, <u>Urgent Care</u>, <u>Prescription Drugs</u> and Certain <u>Therapies</u> <u>Non-Network Providers</u>: Yes. <u>Emergency Room Care</u>, <u>Urgent Care</u> and <u>Prescription Drugs</u></p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For <u>network providers</u>: \$4,500 individual / \$9,000 family For <u>non-network providers</u>: \$13,500 individual / \$27,000 family <u>Pharmacy</u>: \$2,500 individual / \$5,000 family</p>	<p>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.</p>

What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing charges</u> , 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 <u>network provider</u>?	Yes. See www.humana.com/directories or call 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 office or clinic</u>	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /office visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Specialist visit</u>	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	50% <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; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Cost sharing</u> may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.humana.com</p>	Level 1 - Low-cost generic and brand-name drugs	(Retail) \$15 <u>copay/prescription</u> ; <u>deductible</u> does not apply (Mail Order) \$30 <u>copay/prescription</u> ; <u>deductible</u> does not apply	(Retail) 30% <u>coinsurance</u> , after \$15 <u>copay/prescription</u> ; <u>deductible</u> does not apply (Mail Order) 30% <u>coinsurance</u> , after \$30 <u>copay/prescription</u> ; <u>deductible</u> does not apply	(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 Order) 90 day supply. <u>Preauthorization</u> 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 <u>copay/prescription</u> ; <u>deductible</u> does not apply (Mail Order) \$70 <u>copay/prescription</u> ; <u>deductible</u> does not apply	(Retail) 30% <u>coinsurance</u> , after \$35 <u>copay/prescription</u> ; <u>deductible</u> does not apply (Mail Order) 30% <u>coinsurance</u> , after \$70 <u>copay/prescription</u> ; <u>deductible</u> does not apply	
	Level 3 - High-cost, mostly brand-name drugs	(Retail) \$55 <u>copay/prescription</u> ; <u>deductible</u> does not apply (Mail Order) \$110 <u>copay/prescription</u> ; <u>deductible</u> does not apply	(Retail) 30% <u>coinsurance</u> , after \$55 <u>copay/prescription</u> ; <u>deductible</u> does not apply (Mail Order) 30% <u>coinsurance</u> , after \$110 <u>copay/prescription</u> ; <u>deductible</u> does not apply	
	Level 4 - Highest-cost drugs	(Retail) 25% <u>coinsurance</u> ; <u>deductible</u> does not apply (Mail Order) 25% <u>coinsurance</u> ; <u>deductible</u> does not apply	(Retail) 30% <u>coinsurance</u> , after 25% <u>coinsurance</u> ; <u>deductible</u> does not apply (Mail Order) 30% <u>coinsurance</u> , after 25% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	Preferred <u>network</u> specialty pharmacy: 25% <u>coinsurance</u> ; <u>deductible</u> does not apply <u>Network</u> specialty pharmacy: 35% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u> ; <u>deductible</u> does not apply	30 day supply. <u>Preauthorization</u> may be required - if not obtained, member is responsible for 100% of the cost of the drug.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$200 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Emergency room care</u> : <u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> after <u>network deductible</u>	
	<u>Urgent care</u>	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Copay</u> is for the first 3 days per admission.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: \$30 <u>copay/visit</u> ; <u>deductible</u> does not apply Other outpatient services: 20% <u>coinsurance</u>	Therapy: 50% <u>coinsurance</u> Other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	\$200 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Copay</u> is for the first 3 days per admission.
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery facility services.	\$200 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Copay</u> is for the first 3 days per admission. 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	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visit limit per cal yr/ <u>plan yr</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)		
	<u>Rehabilitation services</u>	Physical, occupational, speech, cognitive therapy and manipulations: \$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Physical, occupational, speech, cognitive therapy and manipulations: 50% <u>coinsurance</u>	For <u>network</u> : Physical, occupational, speech, cognitive, and audiology therapy: 60 visits per year combined. Manipulations/adjustments: 25 visits per year. For non-network: Physical, occupational, speech, cognitive, and audiology therapy: 10 visits per year combined. <u>Network</u> and non-network visit limits reduce each other.	
	<u>Habilitation services</u>	Physical, occupational, speech therapy and manipulations: \$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Physical, occupational, speech therapy and manipulations: 50% <u>coinsurance</u>		
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>		60 day limit per cal yr/ <u>plan</u> yr.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>		<u>Preauthorization</u> may be required - if not obtained, penalty will be 50%, non-network <u>providers</u> only. Excludes vehicle and home modifications, exercise and bathroom equipment.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>		None
	If your child needs dental or eye care	Children's eye exam	Not covered		Not covered
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.)

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|-------------------------|--|----------------------------|
| • Bariatric surgery | • Hearing aids | • Private-duty nursing |
| • Child dental check-up | • Infertility treatment | • Routine eye care (Adult) |
| • Child eye exam | • Long-term care | • Weight loss programs |
| • Child glasses | • Non-emergency care when traveling outside the U.S. | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|--|--|---|
| • Acupuncture, if it is prescribed by a physician | • Cosmetic surgery, if for a congenital anomaly, injury, infection, or disease | • Routine foot care, when in treatment for diabetes |
| • 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).
- Indiana Department of Insurance: 800-622-4461 or www.in.gov/idoi.
- 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.
- Indiana Department of Insurance: 800-622-4461 or www.in.gov/idoi.

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)

■ <u>The plan's overall deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ <u>Hospital (facility) copayment</u>	\$200
■ <u>Other coinsurance</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,460

Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ <u>Hospital (facility) copayment</u>	\$200
■ <u>Other coinsurance</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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)

■ <u>The plan's overall deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ <u>Hospital (facility) copayment</u>	\$200
■ <u>Other coinsurance</u>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,050

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

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
If you need help filing a grievance, call **866-427-7478** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 866-427-7478 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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Language assistance services, free of charge, are available to you. 866-427-7478 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resewva sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wóda'hí béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك