
 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, 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 <u>deductible</u> ?	\$750 Individual / \$1,500 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 <u>deductible</u> ?	Yes. Preventive, Certain Office Visits, <u>Emergency Room Care</u> , <u>Urgent Care</u> , <u>Prescription Drugs</u> and Certain therapies.	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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,000 Individual / \$4,000 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>Balance-billing</u> charges, Health care this <u>plan</u> doesn't cover, and Penalties	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 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> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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)	Out-of-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	Primary care visit: \$25 <u>copay/visit</u> ; <u>deductible</u> does not apply Telehealth or telemedicine services: \$25 <u>copay/visit</u> ; <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	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	Not covered	<u>Cost sharing</u> may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	Cost sharing may vary based on where service is performed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.humana.com/2019-Rx4</p>	Level 1 - Lowest cost generic and brand-name drugs	\$10 <u>copay</u> ; <u>deductible</u> does not apply (Retail) \$25 <u>copay</u> ; <u>deductible</u> does not apply (Mail Order)	Not covered (Retail) Not covered (Mail Order)	<p>30 day supply (retail) 90 day supply (mail order) <u>Preauthorization</u> may be required - if not obtained, penalty will be 100% for certain <u>prescription drugs</u>.</p>
	Level 2 - Higher cost generic and brand-name drugs	\$35 <u>copay</u> ; <u>deductible</u> does not apply (Retail) \$87.50 <u>copay</u> ; <u>deductible</u> does not apply (Mail Order)	Not covered (Retail) Not covered (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	\$55 <u>copay</u> ; <u>deductible</u> does not apply (Retail) \$137.50 <u>copay</u> ; <u>deductible</u> does not apply (Mail Order)	Not covered (Retail) Not covered (Mail Order)	
	Level 4 - Highest cost drugs	25% <u>coinsurance</u> ; <u>deductible</u> does not apply (Retail) 25% <u>coinsurance</u> ; <u>deductible</u> does not apply (Mail Order)	Not covered (Retail) Not covered (Mail Order)	
	<u>Specialty drugs</u>	35% <u>coinsurance</u> ; <u>deductible</u> does not apply. 25% <u>coinsurance</u> ; <u>deductible</u> does not apply (Preferred Specialty Pharmacy)	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	\$350 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$350 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> after <u>network deductible</u>	None
	<u>Urgent care</u>	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	None
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: \$25 <u>copay/visit</u> ; <u>deductible</u> does not apply Other outpatient services: 20% <u>coinsurance</u>	Not covered	None
	Inpatient services	20% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	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>	Not covered	100 visits per year.
	<u>Rehabilitation services</u>	Physical, occupational, cognitive, speech and audiology therapy and manipulations: \$50 <u>copay/visit</u> ; <u>deductible</u> does not apply.	Not covered	60 visits per year combined with physical, occupational, cognitive, speech, and audiology therapies including manipulations and adjustments.
	<u>Habilitation services</u>	Physical, occupational, cognitive, speech and audiology therapy and manipulations: \$50 <u>copay/visit</u> ; <u>deductible</u> does not apply.	Not covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	60 days per year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	None
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
- Hearing Aids
- 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
- Chiropractic Care - spinal manipulations are covered
- Cosmetic Surgery, if for a congenital anomaly or reconstruction due to a bodily injury, infection or disease to the involved part
- Dental Care (Adult), if for dental injury of a sound natural tooth
- Infertility Treatment, 6 oocyte retrievals per year

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:

- Humana at 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 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:

- 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.
- Illinois Department of Insurance, 320 West Washington Street, Springfield, IL 62767-0001, Phone: 877-527-9431 or 217-782-4515, TDD 866-323-5321.
- Illinois Department of Insurance, 122 S. Michigan Ave., 19th Floor, Chicago, IL 60603, Phone: 312-814-2420. Website: www.insurance.illinois.gov, Email: DOI.InfoDesk@illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-4ASSIST (427-7478).

-----*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 \$750
- Specialist copayment \$50
- 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$45
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$3,160

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

- The plan's overall deductible \$750
- Specialist copayment \$50
- 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,100
The total Joe would pay is	\$2,800

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

- The plan's overall deductible \$750
- Specialist copayment \$50
- 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) 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; and, (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-800-427-7478** or if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **1-800-427-7478** 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 the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-427-7478 (TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-427-7478 (TTY: 711)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-800-427-7478 (TTY: 711)**。... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-427-7478 (TTY: 711)**... 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-427-7478 (TTY: 711)** 번으로 전화해 주십시오 PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-427-7478 (TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-427-7478 (телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-427-7478 (TTY: 711)**... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-427-7478 (ATS: 711)**... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-427-7478 (TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-427-7478 (TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-427-7478 (TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-427-7478 (TTY: 711)**... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 **1-800-427-7478 (TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-427-7478 (TTY: 711)** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-427-7478 (TTY: 711)**...

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-427-7478 (رقم هاتف الصم والبكم: 711)**.