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 deductible?	Network: $2,500 Individual / $5,000 family; Non-Network: $7,500 Individual / $15,000 family Doesn't apply to prescription drugs and network preventive services. Coinsurance and copayments don't count toward the deductible	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. Preventive, Certain Office Visits, 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 $5,000 individual / $10,000 family; For non-network providers $15,000 individual / $30,000 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.

What is not included in the out-of-pocket limit?	Premiums, Balance-billing charges, Health care this plan doesn't cover, Penalties, Non-network transplant, non-network prescription drugs, non-network specialty drugs	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 1-866-4ASSIST (427-7478) for a list of network providers For Prescription Drugs: National Rx Network	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		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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit; deductible does not apply	50% coinsurance	None
	Specialist visit	$55 copay/visit; deductible does not apply	50% coinsurance	None
	Preventive care / screening / immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need 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	Diagnostic Test: Cost share may vary based on where service is performed Imaging: Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 40%
	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 www.humana.com/2017-Rx4	Level 1 - Lowest cost generic and brand-name drugs	$10 copay (Retail); deductible does not apply $25 copay (Mail Order); deductible does not apply	30% coinsurance, after network copay (Retail); deductible does not apply 30% coinsurance, after network copay (Mail Order); deductible does not apply	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) Non-network cost sharing does not count toward the out-of-pocket limit.
	Level 2 - Higher cost generic and brand-name drugs	$40 copay (Retail); deductible does not apply $100 copay (Mail Order); deductible does not apply	30% coinsurance, after network copay (Retail); deductible does not apply 30% coinsurance, after network copay (Mail Order); 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 3 - Generic and brand-name drugs with higher cost than Level 2	$70 copay (Retail); deductible does not apply $175 copay (Mail Order); deductible does not apply	30% coinsurance, after network copay (Retail); deductible does not apply 30% coinsurance, after network copay (Mail Order); deductible does not apply	
	Level 4 - Highest cost drugs	25% coinsurance (Retail); deductible does not apply 25% coinsurance (Mail Order); deductible does not apply	30% coinsurance, after network Coinsurance (Retail); deductible does not apply 30% coinsurance, after network Coinsurance (Mail Order); deductible does not apply	
	Specialty Drugs	35% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	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	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$350 copay/visit; deductible does not apply	$350 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$100 copay/visit; deductible does not apply	50% coinsurance	

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 hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit; deductible does not apply	50% coinsurance	Inpatient services: Preauthorization may be required - if not obtained, penalty will be 40%
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	No charge; deductible does not apply	50% coinsurance	Office visits: Cost sharing does not apply for preventive services. Childbirth/delivery professional services: Depending on the type of services, a coinsurance or deductible may apply. Childbirth/delivery facility services: Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) Preauthorization may be required - if not obtained, penalty will be 40%
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services.	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	100 visit limit per year Preauthorization may be required - if not obtained, penalty will be 40%

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)	
	Rehabilitation services	$55 copay/visit; deductible does not apply to Manipulations, Occupational Therapy, Speech Therapy, Audiology Therapy, Cognitive Therapy, and Physical Therapy	50% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 40% Manipulations and Therapies: 60 Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, Audiology Therapy visit limit per year includes manipulations & adjustments For non-network, 10 Physical Therapy, Occupational Therapy, Cognitive Therapy, Speech Therapy, Audiology Therapy visits per year includes manipulations & adjustments
	Habilitation services	$55 copay/visit; deductible does not apply to Manipulations, Occupational Therapy, Speech Therapy, Audiology Therapy, Cognitive Therapy, and Physical Therapy	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	60 day limit per year Preauthorization may be required - if not obtained, penalty will be 40%
	Durable medical equipment	20% coinsurance	50% coinsurance	None
	Hospice services	20% coinsurance	50% coinsurance	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 other excluded services.)

- Acupuncture
- Bariatric Surgery
- Child Dental Check-Up
- Child Eye Exam
- Child Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- 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.)

Limitations may apply to these services as permitted by applicable law. These limitations are listed in your plan document.

- Chiropractic Care
- Infertility Treatment

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. 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: http://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.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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	**$2,500**
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$30
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,330**

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

The plan's overall deductible	**$2,500**
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

The plan's overall deductible	**$2,500**
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$1,740**

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

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, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- 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.
- 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 1-866-427-7478 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, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-866-427-7478 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 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-866-427-7478 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-427-7478 (TTY: 711)**.

繁體中文 (Chinese): 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 **1-866-427-7478**（**TTY: 711**）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-866-427-7478 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-866-427-7478 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-427-7478 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-866-427-7478 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-427-7478 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-866-427-7478 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-866-427-7478 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-866-427-7478 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-866-427-7478 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-866-427-7478 (TTY: 711)**.

日本語 (Japanese):
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。 **1-866-427-7478**（**TTY：711**）まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-866-427-7478 (TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-866-427-7478 (TTY: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-427-7478** (رقم هاتف الصم والبكم: **711**).