
 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 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> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not applicable	This <u>plan</u> does not have a <u>deductible</u>
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> ?	\$6,500 Individual / \$13,000 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> , 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</u> charge 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 provider's office or clinic	Primary care visit to treat an injury or illness	Primary care visit: \$40 <u>copay</u> /visit Telehealth or telemedicine services: \$40 <u>copay</u> /visit	Not covered	None
	<u>Specialist visit</u>	\$100 <u>copay</u> /visit	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 provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$600 <u>copay</u> /test	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.humana.com/2020-Rx4-IL .	Level 1 – Low-cost generic and brand-name drugs	\$10 <u>copay</u> (Retail) \$25 <u>copay</u> (Mail Order)	Not covered (Retail) Not covered (Mail Order)	30 day supply (Retail) 90 day supply (Mail order) <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	\$45 <u>copay</u> (Retail) \$112.50 <u>copay</u> (Mail Order)	Not covered (Retail) Not covered (Mail Order)	
	Level 3 - High-cost, mostly brand-name drugs	\$90 <u>copay</u> (Retail) \$225 <u>copay</u> (Mail Order)	Not covered (Retail) Not covered (Mail Order)	
	Level 4 – Highest-cost drugs	25% <u>coinsurance</u> (Retail) 25% <u>coinsurance</u> (Mail Order)	Not covered (Retail) Not covered (Mail Order)	
	<u>Specialty drugs</u>	Preferred <u>network</u> specialty pharmacy: 25% <u>coinsurance</u> <u>Network</u> specialty pharmacy: 35% <u>coinsurance</u>	Not covered	30 day supply. <u>Preauthorization</u> 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)	\$2,000 <u>copay</u> /visit	Not covered	None
	Physician/surgeon fees	No charge	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)	
If you need immediate medical attention	<u>Emergency room care</u>	\$600 <u>copay</u> /visit	\$600 <u>copay</u> /visit	<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	\$600 <u>copay</u> /transport	\$600 <u>copay</u> /transport	None
	<u>Urgent care</u>	\$125 <u>copay</u> /visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,000 <u>copay</u> /day	Not covered	<u>Copay</u> is for the first 3 days per admission.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: \$40 <u>copay</u> /visit Other outpatient non-surgical services: No charge	Not covered	None
	Inpatient services	\$2,000 <u>copay</u> / day	Not covered	<u>Copay</u> is for the first 3 days per admission.
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply to <u>preventive services</u> .
	Childbirth/delivery professional services	No charge	Not covered	Depending on the type of services, a <u>copayment</u> may apply.
	Childbirth/delivery facility services	\$2,000 <u>copay</u> / day	Not covered	<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>	\$100 <u>copay</u> /visit	Not covered	100 visits per year.
	<u>Rehabilitation services</u>	Physical, occupational, cognitive, speech and audiology therapy and manipulations: \$100 <u>copay</u> /visit	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: \$100 <u>copay</u> /visit	Not covered	

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)	
	<u>Skilled nursing care</u>	\$100 <u>copay</u> /visit	Not covered	60 days per year.
	<u>Durable medical equipment</u>	No charge	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	No charge	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.)

- Child dental check-up
- Child eye exam
- Child glasses
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- 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
- Bariatric Surgery
- 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
- Hearing Aids under age 18, 1 per ear every 36 months
- Infertility Treatment, 6 oocyte retrievals per year
- Routine Foot Care, when in treatment for diabetes

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 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:

- 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) (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>	\$0
■ <u>Specialist copayment</u>	\$100
■ <u>Hospital (facility) copayment</u>	\$2,000
■ <u>Other coinsurance</u>	0%

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:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,100
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$2,110

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>	\$0
■ <u>Specialist copayment</u>	\$100
■ <u>Hospital (facility) copayment</u>	\$2,000
■ <u>Other coinsurance</u>	0%

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:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,300

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ <u>The plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$100
■ <u>Hospital (facility) copayment</u>	\$2,000
■ <u>Other coinsurance</u>	0%

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:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,400

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 identity, or religion. 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 **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, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

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

Auxiliary aids and services, free of charge, are available to you. 1-866-427-7478 (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. 1-866-427-7478 (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 níká'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك