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 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: $6,250 Individual / $12,500 family; Non-Network: $25,000 Individual / $50,000 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. Preventive Non-Network Providers: No.	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 $6,250 individual / $12,500 family For non-network providers $30,000 individual / $60,000 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.	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	Preferred network provider virtual visit: No charge after deductible Network provider virtual visit: No charge after deductible Primary care visit: No charge after deductible	Virtual visit: 50% coinsurance Primary care visit: 50% coinsurance	None
	Specialist visit	No charge after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	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)	No charge after deductible	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/2020-HDHP-EHB	Generic and brand-name drugs	No charge after deductible (Retail) (Mail Order) No charge after deductible	(Retail) 50% coinsurance (Mail Order) 50% coinsurance	(Retail) 30 day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug (Mail) 90 day supply Preauthorization 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)	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	No charge after deductible	50% coinsurance	None
If you need immediate medical attention	Emergency room care	No charge after deductible	No charge after deductible	None
	Emergency medical transportation	No charge after deductible	No charge after deductible	
	Urgent care	No charge after deductible	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	No charge after deductible	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	50% coinsurance	None
	Inpatient services	No charge after deductible	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	No charge after deductible	50% coinsurance	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services.	No charge after deductible	50% coinsurance	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 50%
If you need help recovering or have other special health needs	Home health care	No charge after deductible	50% coinsurance	100 visits per year Preauthorization may be required - if not obtained, penalty will be 50%

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	Physical, occupational, speech, cognitive and audiology therapy: No charge after deductible	Physical, occupational, speech, cognitive and audiology therapy: 50% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50% Rehabilitation: Physical, occupational, speech, cognitive and audiology therapy: 40 visits per year combined Habilitation: Physical, occupational, speech, cognitive and audiology therapy: 40 visits per year combined
	Habilitation services	Physical, occupational, speech and audiology therapy: No charge after deductible	Physical, occupational, speech and audiology therapy: 50% coinsurance	
	Skilled nursing care	No charge after deductible	50% coinsurance	60 days per year Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	No charge after deductible	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 after deductible	50% coinsurance	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 other excluded services.)

- Child dental check-up
- Child eye exam
- Child glasses
- Bariatric surgery
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S., when traveling outside the U.S. more than 6 consecutive months in a year
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Long-term care
- Weight loss programs

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

- Manipulations 20 visits per year including manipulations and adjustments.

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.

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 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** **$6,250**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$6,210**

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

- **The plan's overall deductible** **$6,250**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$6,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$6,200**

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

- **The plan's overall deductible** **$6,250**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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