
 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, go to <https://Dowbenefits.ehr.com> or call 1-877-623-8079. 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 www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	This plan does not have a deductible .	This plan does not have a deductible .
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 ?	\$6,350 individual/ \$12,700 family; Includes medical and pharmacy. Medical only: \$2,500 individual/ \$7,500 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 does not cover and penalties for failure to obtain pre-authorization.	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.	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). See www.humana.com to find the HMO Premier network or call 1-800-448-6262 for a list of network providers . 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)	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	\$20 copayment	Not covered	Includes telemedicine services
	Specialist visit	\$35 copayment	Not covered	Cost share may vary based on place of treatment
	Preventive care/screening/immunization	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. Limitations on immunizations are according to the CDC guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Cost shares can vary depending on place of treatment.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Precertification is required; failure to do will result in the service not being covered. Cost share varies depending on place of treatment.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.humana.com and on the Well-being Center.	Level 1 drugs: lowest cost drugs	Retail: \$10 copayment	Not covered.	Prior authorization, step therapy and dispensing limits may be required. Mail order for maintenance drugs is required to avoid a copayment penalty.
	Retail: 30-day supply Mail order : 90-day supply	Mail order: \$25 copayment		
	Level 2 drugs: higher cost drugs	Retail: \$30 copayment	Not covered	Prior authorization, step therapy and dispensing limits may be required. Mail order for maintenance drugs is required to avoid a copayment penalty.
	Retail: 30-day supply Mail order: 90-day supply	Mail order: \$75 copayment		
	Level 3 drugs: higher cost brand name medicines	Retail: \$50 copayment	Not covered	Prior authorization, step therapy and dispensing limits may be required. Mail order for maintenance drugs is required to avoid a copayment penalty.
	Retail: 30-day supply Mail order: 90-day supply	Mail order: \$125 copayment		
Level 4 drugs – Highest	25% of charge	Not covered	Prior authorization, step therapy and dispensing limits	

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)	
	cost drugs Specialty drugs	Self-administered: copayment or coinsurance depends on Drug Tier level; Injectable medicines: Applicable medical copayment applies depending on the place of treatment	Not covered	may be required. Self-administered <u>specialty drugs</u> are covered under the pharmacy benefit. Injectable <u>specialty drugs</u> received in office, clinic or outpatient setting are typically covered under medical. Prior authorization and/or step therapy and dispensing limitations may apply. Specialty Drugs (Qualified Practitioner's Office Visit, Freestanding Facility and Urgent Care, Home Health Care)100% after a \$50 copayment.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 <u>copayment</u>	Not covered	Precertification is required; failure to do will result in the service not being covered.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	\$150 <u>copayment</u>	\$150 <u>copayment</u>	Copayment is waived if admitted as an inpatient.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$35 <u>copayment</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copayment</u> per day up to \$600 per confinement	Not covered	Precertification is required; failure to do will result in the service not being covered.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u>	Not covered	None
	Inpatient services	\$200 <u>copayment</u> per day up to \$600 per confinement	Not covered	Precertification is required; failure to do will result in the service not being covered.
If you are pregnant	Office visits	\$50 <u>copayment</u> (initial visit only)	Not covered	None
	Childbirth/delivery professional services	\$50 <u>copayment</u> (initial visit only)	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)	
	Childbirth/delivery facility services	\$200 <u>copayment</u> per day up to \$600 per confinement	Not covered	The mother's and baby's hospital charges are usually combined and only one copayment applies per day (maximum \$600 per confinement) until the mother's date of discharge. Notification of admission is requested, but not required.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Precertification is required; failure to do will result in the service not being covered. Limited to 60 visits per plan year.
	Rehabilitation services	\$35 <u>copayment</u>	Not covered	Precertification is required; failure to do will result in the service not being covered. Limited to 20 visits per plan year.
	Habilitation services	\$35 <u>copayment</u>	Not covered	Precertification is required; failure to do will result in the service not being covered. Limited to 20 visits per plan year. Covered for autism.
	Skilled nursing care	\$200 <u>copayment</u> per day up to \$600 per confinement	Not covered	Precertification is required; failure to do will result in the service not being covered. Limited to 90 days per plan year.
	Durable medical equipment	20% <u>coinsurance</u>	Not covered	Precertification may be required. Monthly rental is allowed, but not to exceed the purchase price of DME.
	Hospice services	No charge	Not covered	Precertification is required; failure to do will result in the service not being covered. Limited to 180 days for bereavement.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copayment</u>	Not covered	Limited to one <u>refraction</u> /per year.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups.

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](#).)

- | | | |
|------------------------|---|------------------------|
| • Acupuncture | • Hearing aids (adults) | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (adults) | • Non-emergency care while traveling outside the U.S. | • Weight-loss programs |

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

- | | | |
|---------------------|---|---------------------------------------|
| • Bariatric surgery | • Hearing aids (80% coverage for ages 17 and younger, for non-disposable aids up to \$1,400 per hearing aid, every 36 months) | • Infertility treatment (covered 50%) |
| • Chiropractic care | | • Routine eye exam |

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 at 1-888-357-6767 or the Department of Labor's Employee Benefits Security Administration at 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 the 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: See the attached Addendum.

-----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](#) \$0
- [Specialist](#) [*cost sharing*] \$35
- Hospital (facility) [*cost sharing*] \$600
- Other [*cost sharing*] 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	\$12,731
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$680
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$740

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$35
- Hospital (facility) [*cost sharing*] \$600
- Other [*cost sharing*] 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	\$7,390
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,640
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$1,114
The total Joe would pay is	\$2,754

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$35
- Hospital (facility) [*cost sharing*] \$600
- Other [*cost sharing*] 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	\$1,888
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$395
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$435

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 1-877-320-1235 or send an email to accessibility@humana.com, 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 1-877-320-1235 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
(TTY: 711).

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

한국어 (Korean): 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(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
(TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните
(телетайп: 711).

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

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

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer
(TTY: 711).

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

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

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:
(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。
(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
(TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): 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
(TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
(رقم هاتف الصم والبكم: 711).