
 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, 1-800-314-3121. 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.humana.com](http://www.humana.com) or call 1-800-314-3121 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	You don't have to meet <a href="#">deductibles</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes, For Out-of-Network providers \$100 Individual; \$300 Family	You must pay all of the costs for these services up to the specific deductible amount before this <a href="#">plan</a> begins to pay for <a href="#">out-of-network provider</a> services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2000 Individual \$6000 Family (In-Network)	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Out-of-network services, cost-shares, premiums and not covered services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.humana.pr">www.humana.pr</a> or call 1-800-314-3121 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit	\$17 <a href="#">copay</a> /visit	Covered by reimbursement at contracted fee. \$17 <a href="#">copay</a> /visit	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit	\$22 <a href="#">copay</a> /visit	Covered by reimbursement at contracted fee. \$22 <a href="#">copay</a> /visit	None
	<a href="#">Preventive care/screening/immunization</a>	No copay	No copay	Covered by reimbursement at contracted fee	Based on Federal Healthcare Reform / Affordable Care Act (ACA).  You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No coinsurance	No coinsurance	Covered by reimbursement at contracted fee 25% <a href="#">coinsurance</a> /test	None
	Imaging (CT/PET scans, MRIs)	No coinsurance	No coinsurance	Covered by reimbursement at contracted fee 25% <a href="#">coinsurance</a> /test	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.humana.com">www.humana.com</a> .	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail) \$20 <a href="#">copay</a> /prescription (mail order)		Not covered	Formulary: F50 (RX-2)  Retail - Covers up to a 30-day supply. Mail order – Covers up to a 90-day supply.  MAC A (Generics mandatory)
	Brand drugs (Tier 2)	\$25 <a href="#">copay</a> /prescription (retail) \$50 <a href="#">copay</a> /prescription (mail order)	\$25 <a href="#">copay</a> /prescription (retail) \$50 <a href="#">copay</a> /prescription (mail order)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No copay	\$25 <a href="#">copay</a> /facility	Covered by reimbursement at contracted fee. \$25 <a href="#">copay</a> /facility	None
	Physician/surgeon fees	No coinsurance	25% <a href="#">coinsurance</a> /surgery	Covered by reimbursement at contracted fee. 25% <a href="#">coinsurance</a> /surgery	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> /illness visit \$0 <a href="#">copay</a> /accident visit	\$60 <a href="#">copay</a> /illness visit \$0 <a href="#">copay</a> /accident visit	Covered by reimbursement at contracted fee \$60 <a href="#">copay</a> /illness visit	None
	<a href="#">Emergency medical transportation</a>	\$0 <a href="#">copay</a> /trip between facilities \$25 <a href="#">copay</a> /ground trip 50% <a href="#">coinsurance</a> /air or maritime trip	\$0 <a href="#">copay</a> /trip between facilities \$25 <a href="#">copay</a> /ground trip 50% <a href="#">coinsurance</a> /air or maritime trip	Covered by reimbursement at contracted fee. \$0 <a href="#">copay</a> /trip between facilities \$25 <a href="#">copay</a> /ground trip 50% <a href="#">coinsurance</a> /air or maritime trip	Maritime and air aerial transportation (within the territorial limits of P.R.) and air transportation between U.S. and P.R. is covered after <a href="#">preauthorization</a> , unless the nature of the emergency does not allow it.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /illness visit \$0 <a href="#">copay</a> /accident visit	\$60 <a href="#">copay</a> /illness visit \$0 <a href="#">copay</a> /accident visit	Covered by reimbursement at contracted fee \$60 <a href="#">copay</a> /illness visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <a href="#">copay</a> /stay	\$150 <a href="#">copay</a> /stay	Covered by reimbursement at contracted fee \$150 <a href="#">copay</a> /stay	Pre-notification is not required for admissions through emergency.  Excluded: Private room, expenses related to personal convenience, private nurse, unless in cases previously approved by Humana; personal use items, such as television, phone or "admission kit".
	Physician/surgeon fees	No coinsurance	25% <a href="#">coinsurance</a> /surgery	Covered by reimbursement at contracted fee. 25% <a href="#">coinsurance</a> /surgery	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> /visit	\$22 <a href="#">copay</a> /visit	Covered by reimbursement at contracted fee. \$22 <a href="#">copay</a> /visit	None
	Inpatient services	\$100 <a href="#">copay</a> /stay	\$150 <a href="#">copay</a> /stay	Covered by reimbursement at contracted fee \$150 <a href="#">copay</a> /stay	
If you are pregnant	Office visits	\$15 <a href="#">copay</a> /visit	\$17 <a href="#">copay</a> /visit	Covered by reimbursement at contracted fee. \$17 <a href="#">copay</a> /visit	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copay</a> may apply. Maternity care

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
	Childbirth/delivery professional services	No coinsurance	25% <a href="#">coinsurance</a> /surgery	Covered by reimbursement at contracted fee. 25% <a href="#">coinsurance</a> /surgery	may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$100 <a href="#">copay</a> /stay	\$150 <a href="#">copay</a> /stay	Covered by reimbursement at contracted fee \$150 <a href="#">copay</a> /stay	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No coinsurance	25% <a href="#">coinsurance</a> /surgery	Covered by reimbursement at contracted fee. 25% <a href="#">coinsurance</a> /surgery	Services must start in the first 30 days after the discharge from the hospital or skilled nursing facility and may be provided in substitution of an admission. <a href="#">Preauthorization</a> is required.  Home health services may include services described elsewhere in the SBC (i.e. specialist visit, physical therapy).
	<a href="#">Rehabilitation services</a>	No coinsurance for therapies. \$20 <a href="#">copay</a> /chiropractor visit	25% <a href="#">coinsurance</a> /therapy session. \$22 <a href="#">copay</a> /chiropractor visit	Covered by reimbursement at contracted fee 25% <a href="#">coinsurance</a> /therapy session. \$22 <a href="#">copay</a> /chiropractor visit	Rehabilitation services, including speech therapy, occupational therapy and physical therapy, are covered for conditions subject to improve within sixty (60) days. <a href="#">Pre-autorización</a> required.
	<a href="#">Habilitation services</a>	No coinsurance for therapies. \$20 <a href="#">copay</a> /chiropractor visit	25% <a href="#">coinsurance</a> /therapy session. \$22 <a href="#">copay</a> /chiropractor	Covered by reimbursement at contracted fee	Chiropractic services are covered fifteen (15) manipulations, per subscriber per contract year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Services provided or arranged by your Participating Primary Care Physician (You will pay the least)	Services accessed directly with Network Providers	Out-of-Network Providers (You will pay the most)	
			visit	25% <a href="#">coinsurance</a> /therapy session. \$22 <a href="#">copay</a> /chiropractor visit	
	<a href="#">Skilled nursing care</a>	No copay	\$25 <a href="#">copay</a> /facility	Covered by reimbursement at contracted fee. \$25 <a href="#">copay</a> /facility	Maximum sixty 60 days per subscriber in lifetime. Must comply with medical necessity.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a> /equipment	50% <a href="#">coinsurance</a> /equipment	Covered by reimbursement at contracted fee 50% <a href="#">coinsurance</a> /equipment	<a href="#">Preauthorization</a> is required.
	<a href="#">Hospice services</a>	No coinsurance	25% <a href="#">coinsurance</a> /surgery	Covered by reimbursement at contracted fee. 25% <a href="#">coinsurance</a> /surgery	<a href="#">Preauthorization</a> is required.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 <a href="#">copay</a> /exam	\$22 <a href="#">copay</a> /exam	Covered by reimbursement at contracted fee. \$20 <a href="#">copay</a> /exam	One (1) refraction test per contract year.
	Children's glasses	Not covered	Not covered	Not covered	Vision discount available with Eyemed.
	Children's dental check-up	Not covered	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](#).)

<ul style="list-style-type: none"><li>• Infertility Treatment</li><li>• Acupuncture</li></ul>	<ul style="list-style-type: none"><li>• Long Term Care</li><li>• Cosmetic Surgery</li><li>• Private Duty Nursing</li></ul>	<ul style="list-style-type: none"><li>• Weight Loss Programs</li><li>• Hearing Aids</li><li>• Dental Care</li><li>• Non-emergency care when traveling outside the U.S. (unless dependent is studying in U.S.)</li></ul>
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Chiropractic Care</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine Foot Care</li></ul>
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**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> or you can contact the Puerto Rico Office of the Commissioner of Insurance. 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](http://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 our customer service department at 1-800-314-3121.

### 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 1-800-314-3121.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-314-3121.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-314-3121.]

[Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-800-314-3121.]

————— *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 copayment](#) \$15
- [Hospital \(facility\) copayment](#) \$100
- 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*)

<b>Total Example Cost</b>	<b>\$6,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$325
Coinsurance	\$290
<i>What isn't covered</i>	
Limits or exclusions	\$570
<b>The total Peg would pay is</b>	<b>\$1,185</b>

**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 copayment](#) \$15
- [Hospital \(facility\) copayment](#) \$100
- 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*)

<b>Total Example Cost</b>	<b>\$6,100</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copayments	\$440
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Joe would pay is</b>	<b>\$840</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- [Hospital \(facility\) copayment](#) \$100
- 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*)

<b>Total Example Cost</b>	<b>\$1,200</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copayments	\$150
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$210</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact 1-800-314-3121.

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.