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, insert contact information. 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 or call 1-800-314-3121 to request a copy.

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?	Yes. Services with network providers.	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?	Yes. Out-of-network providers: Single $100/Family 300	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network providers: Single $2,000/Family $6,000	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 and health care this plan doesn't cover.	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 or call 1-800-314-3121.	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
		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 provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	$17 copay/visit	Covered by reimbursement at contracted fee. $17 copay/visit	Virtual Consult: $17 copay; visit www.mdlive.com/humanapr
	Specialist visit	$20 copay/visit	$22 copay/visit	Covered by reimbursement at contracted fee. $22 copay/visit	None
	Preventive care/screening/ immunization	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 preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No coinsurance	No coinsurance	Covered by reimbursement at contracted fee 25% coinsurance /test	Preauthorization is required for genetic testing.
	Imaging (CT/PET scans, MRIs)	No coinsurance	No coinsurance	Covered by reimbursement at contracted fee 25% coinsurance /test	None
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	$10 copay/ retail $20 copay/ mail order	$10 copay/ retail $20 copay/ mail order	Not covered	Formulary: F50 (Rx2 Traditional)

* For more information about limitations and exceptions, review the plan or policy document, call 1-800-314-3121.

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)	
More information about **prescription drug coverage** is available at www.humana.com/druglist	Brand drugs (Tier 2)	$25 copay/ retail $50 copay/ mail order	$25 copay/ retail $50 copay/ mail order	Not covered	30-day retail supply. 90-day mail-order supply. MAC A (Mandatory Generic)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No copay	$25 copay/facility	Covered by reimbursement at contracted fee. $25 copay/facility	None
	Physician/surgeon fees	No copay	25% coinsurance/ surgery	Covered by reimbursement at contracted fee. 25% coinsurance/ surgery	
If you need immediate medical attention	Emergency room care	$50 copay/illness visit $0 copay/accident visit	$60 copay/illness visit $0 copay/accident visit	Covered by reimbursement at contracted fee $60 copay/illness visit	None
	Emergency medical transportation	$25 copay/ ground trip 50% coinsurance/ air or maritime trip	$25 copay/ ground trip 50% coinsurance/ air or maritime trip	Covered by reimbursement at contracted fee. $25 copay/ ground trip 50% coinsurance/ air or maritime trip	$0 copay/ trip between facilities. Maritime and air aerial transportation (within the territorial limits of P.R.) and air transportation between U.S. and P.R. is covered after preauthorization, unless the nature of the emergency does not allow it.
	Urgent care	$50 copay/illness visit	$60 copay/illness visit	Covered by reimbursement at	None

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)	
		$0 copay/accident visit	$0 copay/accident visit	contracted fee $60 copay/illness visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/stay	$150 copay/stay	Covered by reimbursement at contracted fee $150 copay/stay	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% coinsurance/ surgery	Covered by reimbursement at contracted fee. 25% coinsurance/ surgery	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	$22 copay/visit	Covered by reimbursement at contracted fee. $22 copay/visit	None
	Inpatient services	$100 copay/stay	$150 copay/stay	Covered by reimbursement at contracted fee $150 copay/stay	Partial hospitalization is covered without cost share. Preauthorization is required
If you are pregnant	Office visits	$15 copay/visit	$17 copay/visit	Covered by reimbursement at contracted fee. $17 copay/visit	None
	Childbirth/delivery professional services	No coinsurance	25% coinsurance/ surgery	Covered by reimbursement at contracted fee.	

* For more information about limitations and exceptions, review the plan or policy document, call 1-800-314-3121.

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)	
				25% coinsurance/ surgery	
	Childbirth/delivery facility services	$100 copay/stay	$150 copay/stay	Covered by reimbursement at contracted fee $150 copay/stay	
If you need help recovering or have other special health needs	Home health care	No cost	25% coinsurance/ surgery	Covered by reimbursement at contracted fee. 25% coinsurance/ surgery	Covered 30 initial days and 30 additional days per medical criteria and when medically necessary. Subject to medical necessity.
	Rehabilitation services	No coinsurance for therapies.	25% coinsurance/ therapy session.	Covered by reimbursement at contracted fee 25% coinsurance/ therapy session.	Includes speech therapy, occupational therapy and physical therapy, are covered for conditions subject to improve within sixty (60) days. Preauthorization required.
	Habilitation services	No coinsurance for therapies.	25% coinsurance/ therapy session.	Covered by reimbursement at contracted fee 25% coinsurance/ therapy session. $17 copay/chiropractor visit	
	Skilled nursing care	No copay	$25 copay/facility	Covered by reimbursement at contracted fee. $25 copay/facility	Maximum sixty 60 days per subscriber in lifetime. Must comply with medical necessity.
	Durable medical equipment	50% coinsurance	50% coinsurance	Covered by reimbursement at contracted fee.	Preauthorization required.

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)	
				50% coinsurance	
	Hospice services	No coinsurance	25% coinsurance/ services	Covered by reimbursement at contracted fee. 25% coinsurance/ services	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	$20 copay/exam	$22 copay/exam	Covered by reimbursement at contracted fee. $22 copay/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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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
- Chiropractic Care – 1 initial visit/1 subsequent; 15 manipulations
- Routine eye care (Adult) – 1 eye exam per contract year
- Routine Foot Care

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 Employee Benefits Security Administration of Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage. For more information about individual insurance coverage, visit the Office of the Commissioner of Insurance of Puerto Rico, , http://ocs.pr.gov/ocspr/.

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 on how 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

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 at'ohwol ninisingo, kwiijigo 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	**25%**

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	**$6,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$325
Coinsurance	$290
What isn't covered	
Limits or exclusions	$1,070
The total Peg would pay is	**$1,185**

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	**25%**

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	**$6,100**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$440
Coinsurance	$330
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$840**

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	**25%**

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	**$1,200**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$25
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$210**

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