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 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 866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $0 individual / $0 family; Non-Network: $5,000 individual / $10,000 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: Not Applicable. Non-Network Providers: Yes. Emergency Room Care and Prescription Drugs	This plan does not have a network deductible. 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: $7,900 individual / $15,800 family For non-network providers: $23,700 individual / $47,400 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 for failure to obtain preauthorization for services, non-network transplant, non-network prescription drugs, non-network specialty drugs, non-network immune effector cell therapy	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 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	Telehealth or telemedicine services: $40 copay/office visit Primary care visit: $40 copay/office visit	Telehealth or telemedicine services: 30% coinsurance Primary care visit: 30% coinsurance	None
	Specialist visit	$80 copay/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% 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	30% coinsurance	Imaging: Preauthorization may be required - if not obtained, penalty will be 50%.
	Imaging (CT/PET scans, MRIs)	$600 copay/visit	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.humana.com/2023-Rx4-IL-MO-UT	Level 1 - Low-cost generic and brand-name drugs	(Retail) $10 copay/prescription (Mail Order) $25 copay/prescription	(Retail) 30% coinsurance, after $10 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $25 copay/prescription; deductible does not apply	(Retail) 30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug. (Mail Order) 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)	
	Level 2 - Higher-cost generic and brand-name drugs	(Retail) $40 copay/prescription (Mail Order) $100 copay/prescription	(Retail) 30% coinsurance, after $40 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $100 copay/prescription; deductible does not apply	
	Level 3 - High-cost, mostly brand-name drugs	(Retail) $70 copay/prescription (Mail Order) $175 copay/prescription	(Retail) 30% coinsurance, after $70 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $175 copay/prescription; deductible does not apply	
	Level 4 - Highest-cost drugs	(Retail) 25% coinsurance (Mail Order) 25% coinsurance	(Retail) 30% coinsurance, after 25% coinsurance; deductible does not apply (Mail Order) 30% coinsurance, after 25% coinsurance; deductible does not apply	
	Specialty drugs	Preferred network specialty pharmacy: 25% coinsurance Network specialty pharmacy: 35% coinsurance	50% coinsurance; deductible does not apply	30 day supply. Preauthorization 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)	$2000 copay/visit	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$600 copay/visit	$600 copay/visit	Emergency room care: Copayment waived if admitted.
	Emergency medical transportation	$600 copay/transport	$600 copay/transport	

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)	
	Urgent care	$125 copay/visit	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$2000 copay/day	30% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 50%.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $40 copay/visit Outpatient hospital non-surgical services: No charge	Therapy: 30% coinsurance Outpatient hospital non-surgical services: 30% coinsurance	None
	Inpatient services	$2000 copay/day	30% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 50%.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	30% coinsurance	Depending on the type of services, a copayment may apply.
	Childbirth/delivery facility services.	$2000 copay/day	30% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 50%. 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	Home health care	$80 copay/visit	30% coinsurance	100 visits per yr. 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 and occupational therapy: $40 copay/visit Speech, cognitive, audiology therapy and manipulations: $80 copay/visit	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 30% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50%. Physical, occupational, speech, cognitive, audiology therapy and manipulations (performed by a provider other than a licensed chiropractor): For network, 60 visits per year combined. For non-network, 10 visits per year combined. Network and non-network visit limits reduce each other.
	Habilitation services	Physical and occupational therapy: $40 copay/visit Speech, audiology therapy and manipulations: $80 copay/visit	Physical, occupational, speech, audiology therapy and manipulations: 30% coinsurance	
	Skilled nursing care	$80 copay/day	30% coinsurance	60 days per yr. Preauthorization may be required - if not obtained, penalty will be 50%.
	Durable medical equipment	No charge	30% 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	30% 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 any other excluded services.)		
• Bariatric surgery	• Infertility treatment	• Routine eye care (Adult)
• Child dental check-up	• Long-term care	• Routine foot care
• Child eye exam	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Child glasses	• Private-duty nursing	

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	• Cosmetic surgery, if to correct a functional impairment	• Hearing aids, for a newborn
• Chiropractic care - spinal manipulations are covered	• Dental care (Adult), if for dental injury of a sound natural tooth	

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 866-4ASSIST (427-7478).
- Missouri Department of Commerce and Insurance: 800-726-7390 or www.insurance.mo.gov.
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 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 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 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 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:

- www.humana.com or 866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Missouri Department of Commerce and Insurance: 800-726-7390 or www.insurance.mo.gov.

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 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 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)

The plan's overall deductible	$0
Specialist copayment	$80
Hospital (facility) copayment	$2000
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$4,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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	$80
Hospital (facility) copayment	$2000
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$0
Specialist copayment	$80
Hospital (facility) copayment	$2000
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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

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, gender identity, ancestry, ethnicity, marital status, religion or language. 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 **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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 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. 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 resevwa 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): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.

العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك