



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 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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | <u>Network Providers</u> : \$0 individual / \$0 family;<br><u>Non-Network Providers</u> : \$6,000 individual / \$12,000 family                                                                                                                                                                                     | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                                                 |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | <u>Network Providers</u> :<br>Not Applicable.<br><u>Non-Network Providers</u> :<br>Yes. <u>Emergency Room Care</u>                                                                                                                                                                                                 | This <u>plan</u> does not have a <u>network deductible</u> . This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                                                                                                                | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For <u>network providers</u> :<br>\$8,550 individual / \$17,100 family;<br>For <u>non-network providers</u> :<br>\$34,200 individual / \$68,400 family                                                                                                                                                             | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                                       |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>preauthorization</u> for services, non-network transplant, non-network <u>prescription drugs</u> , non-network <u>specialty drugs</u> , non-network immune effector cell therapy. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| Important Questions                                        | Answers                                                                                                                                                     | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <u>network provider</u> ?   | Yes. See <a href="http://www.humana.com/directories">www.humana.com/directories</a> or call 866-4ASSIST (427-7478) for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No.                                                                                                                                                         | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 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<br>(You will pay the least)                                                                                                                                                         | Non-Network Provider<br>(You will pay the most)                                           |                                                                                                                                                                         |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | Preferred <u>network provider</u> virtual visit:<br>No charge<br><u>Network provider</u> virtual visit:<br>\$55 <u>copay</u> /office visit<br>Primary care visit:<br>\$55 <u>copay</u> /office visit | Virtual visit:<br>50% <u>coinsurance</u><br>Primary care visit:<br>50% <u>coinsurance</u> | None                                                                                                                                                                    |
|                                                               | <u>Specialist</u> visit                          | \$100 <u>copay</u> /visit                                                                                                                                                                            | 50% <u>coinsurance</u>                                                                    | None                                                                                                                                                                    |
|                                                               | <u>Preventive care/screening</u> /immunization   | No charge                                                                                                                                                                                            | 50% <u>coinsurance</u>                                                                    | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test                                            | <u>Diagnostic test</u> (x-ray, blood work)       | No charge                                                                                                                                                                                            | 50% <u>coinsurance</u>                                                                    | Imaging:<br><u>Preauthorization</u> may be required - if not obtained, penalty will be 50%.                                                                             |
|                                                               | Imaging (CT/PET scans, MRIs)                     | \$950 <u>copay</u> /visit                                                                                                                                                                            | 50% <u>coinsurance</u>                                                                    |                                                                                                                                                                         |

| Common Medical Event                                                                                                                                                                                                  | Services You May Need                                                   | What You Will Pay                                                                                                                                   |                                                                                                                                                                                                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                       |                                                                         | Network Provider<br>(You will pay the least)                                                                                                        | Non-Network Provider<br>(You will pay the most)                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="https://www.humana.com/2023-Rx5">https://www.humana.com/2023-Rx5</a> | Level 1 - Preferred, lowest-cost generic drugs                          | (Retail) \$5 <u>copay</u> /prescription<br>(Mail Order) \$12.50 <u>copay</u> /prescription                                                          | (Retail) 30% <u>coinsurance</u> , after \$5 <u>copay</u> /prescription; <u>deductible</u> does not apply<br>(Mail Order) 30% <u>coinsurance</u> , after \$12.50 <u>copay</u> /prescription; <u>deductible</u> does not apply | (Retail) 30 day supply.<br><u>Preauthorization</u> may be required - if not obtained, member is responsible for 100% of the cost of the drug.<br>(Mail Order) 90 day supply.<br><u>Preauthorization</u> may be required - if not obtained, member is responsible for 100% of the cost of the drug. |
|                                                                                                                                                                                                                       | Level 2 - Low-cost generic drugs                                        | (Retail) \$20 <u>copay</u> /prescription<br>(Mail Order) \$50 <u>copay</u> /prescription                                                            | (Retail) 30% <u>coinsurance</u> , after \$20 <u>copay</u> /prescription; <u>deductible</u> does not apply<br>(Mail Order) 30% <u>coinsurance</u> , after \$50 <u>copay</u> /prescription; <u>deductible</u> does not apply   |                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                       | Level 3 - Preferred brand-name drugs and higher-cost generic drugs      | (Retail) \$50 <u>copay</u> /prescription<br>(Mail Order) \$125 <u>copay</u> /prescription                                                           | (Retail) 30% <u>coinsurance</u> , after \$50 <u>copay</u> /prescription; <u>deductible</u> does not apply<br>(Mail Order) 30% <u>coinsurance</u> , after \$125 <u>copay</u> /prescription; <u>deductible</u> does not apply  |                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                       | Level 4 - Non-preferred brand-name drugs and high-cost generic drugs    | (Retail) \$100 <u>copay</u> /prescription<br>(Mail Order) \$250 <u>copay</u> /prescription                                                          | (Retail) 30% <u>coinsurance</u> , after \$100 <u>copay</u> /prescription; <u>deductible</u> does not apply<br>(Mail Order) 30% <u>coinsurance</u> , after \$250 <u>copay</u> /prescription; <u>deductible</u> does not apply |                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                       | Level 5 - Highest-cost/high technology drugs and <u>specialty drugs</u> | Preferred <u>network</u> specialty pharmacy:<br>\$450 <u>copay</u> /prescription<br>Network specialty pharmacy:<br>\$500 <u>copay</u> /prescription | (Retail) 30% <u>coinsurance</u> , after \$500 <u>copay</u> /prescription; <u>deductible</u> does not apply                                                                                                                   | 30 day supply.<br><u>Preauthorization</u> 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<br>(You will pay the least)                                                                     | Non-Network Provider<br>(You will pay the most)                                                            |                                                                                                                                                                                                                      |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | \$2,500 <u>copay</u> /visit                                                                                      | 50% <u>coinsurance</u>                                                                                     | <u>Preauthorization</u> may be required - if not obtained, penalty will be 50%.                                                                                                                                      |
|                                                                           | Physician/surgeon fees                         | No charge                                                                                                        | 50% <u>coinsurance</u>                                                                                     | None                                                                                                                                                                                                                 |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$950 <u>copay</u> /visit                                                                                        | \$950 <u>copay</u> /visit                                                                                  | <u>Emergency room care</u> :<br><u>Copayment</u> waived if admitted.                                                                                                                                                 |
|                                                                           | <u>Emergency medical transportation</u>        | \$950 <u>copay</u> /transport                                                                                    | \$950 <u>copay</u> /transport;<br><u>deductible</u> does not apply                                         |                                                                                                                                                                                                                      |
|                                                                           | <u>Urgent care</u>                             | \$100 <u>copay</u> /visit                                                                                        | 50% <u>coinsurance</u>                                                                                     |                                                                                                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | \$2,500 <u>copay</u> /day                                                                                        | 50% <u>coinsurance</u>                                                                                     | 3 days for <u>copay</u> per day.<br><u>Preauthorization</u> may be required - if not obtained, penalty will be 50%.                                                                                                  |
|                                                                           | Physician/surgeon fees                         | No charge                                                                                                        | 50% <u>coinsurance</u>                                                                                     | None                                                                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Therapy:<br>\$55 <u>copay</u> /visit<br>Outpatient hospital non-surgical services:<br>\$2500 <u>copay</u> /visit | Therapy:<br>50% <u>coinsurance</u><br>Outpatient hospital non-surgical services:<br>50% <u>coinsurance</u> | None                                                                                                                                                                                                                 |
|                                                                           | Inpatient services                             | \$2500 <u>copay</u> /day                                                                                         | 50% <u>coinsurance</u>                                                                                     | 3 days for <u>copay</u> per day.<br><u>Preauthorization</u> may be required - if not obtained, penalty will be 50%.                                                                                                  |
| If you are pregnant                                                       | Office visits                                  | No charge                                                                                                        | 50% <u>coinsurance</u>                                                                                     | <u>Cost sharing</u> does not apply for <u>preventive services</u> .                                                                                                                                                  |
|                                                                           | Childbirth/delivery professional services      | No charge                                                                                                        | 50% <u>coinsurance</u>                                                                                     | Depending on the type of services, a <u>copayment</u> may apply.                                                                                                                                                     |
|                                                                           | Childbirth/delivery facility services          | \$2500 <u>copay</u> /day                                                                                         | 50% <u>coinsurance</u>                                                                                     | 3 days for <u>copay</u> per day.<br><u>Preauthorization</u> 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). |

| Common Medical Event                                           | Services You May Need            | What You Will Pay                                                                            |                                                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | Network Provider<br>(You will pay the least)                                                 | Non-Network Provider<br>(You will pay the most)                                            |                                                                                                                                                                                                                                                                                                                                                                          |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | \$100 <u>copay</u> /visit                                                                    | 50% <u>coinsurance</u>                                                                     | 100 visits per year.<br><u>Preauthorization</u> may be required - if not obtained, penalty will be 50%.                                                                                                                                                                                                                                                                  |
|                                                                | <u>Rehabilitation services</u>   | Physical, occupational, speech, cognitive and audiology therapy:<br>\$55 <u>copay</u> /visit | Physical, occupational, speech, cognitive and audiology therapy:<br>50% <u>coinsurance</u> | Therapies:<br><u>Preauthorization</u> may be required - if not obtained, penalty will be 50%.<br><br><u>Rehabilitation services</u> :<br>Physical, occupational, speech, cognitive and audiology therapy:<br>40 visits per year combined.<br><br><u>Habilitation services</u> :<br>Physical, occupational, speech and audiology therapy:<br>40 visits per year combined. |
|                                                                | <u>Habilitation services</u>     | Physical, occupational, speech and audiology therapy:<br>\$55 <u>copay</u> /visit            | Physical, occupational, speech and audiology therapy:<br>50% <u>coinsurance</u>            |                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                | <u>Skilled nursing care</u>      | \$100 <u>copay</u> /day                                                                      | 50% <u>coinsurance</u>                                                                     | 60 days per year.<br><u>Preauthorization</u> may be required - if not obtained, penalty will be 50%.                                                                                                                                                                                                                                                                     |
|                                                                | <u>Durable medical equipment</u> | No charge                                                                                    | 50% <u>coinsurance</u>                                                                     | <u>Preauthorization</u> may be required - if not obtained, penalty will be 50%.<br>Excludes vehicle and home modifications exercise and bathroom equipment.                                                                                                                                                                                                              |
|                                                                | <u>Hospice services</u>          | No charge                                                                                    | 50% <u>coinsurance</u>                                                                     | <u>Preauthorization</u> 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                                                                                                                                                                                                                                                                                                                                                                     |

| Common Medical Event | Services You May Need      | What You Will Pay                            |                                                 | Limitations, Exceptions, & Other Important Information |
|----------------------|----------------------------|----------------------------------------------|-------------------------------------------------|--------------------------------------------------------|
|                      |                            | Network Provider<br>(You will pay the least) | Non-Network Provider<br>(You will pay the most) |                                                        |
|                      | Children's dental check-up | Not covered                                  | Not covered                                     | None                                                   |

#### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                                                      |                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------|--|
| • Bariatric surgery                                                                                                                                                    | • Hearing aids                                       | • Private-duty nursing     |  |
| • Child dental check-up                                                                                                                                                | • Infertility treatment                              | • Routine eye care (Adult) |  |
| • Child eye exam                                                                                                                                                       | • Long-term care                                     | • Routine foot care        |  |
| • Child glasses                                                                                                                                                        | • Non-emergency care when 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 <u>plan</u> document.) |                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| • Acupuncture (if it is prescribed by a physician)                                                                                  | • Cosmetic surgery (if to correct a functional impairment)            |
| • Chiropractic care (spinal manipulations are covered to 20 visits per year)                                                        | • 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](http://www.humana.com) or 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 866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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](http://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](http://www.dol.gov/ebsa/healthreform).

**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 <u>deductible</u> | \$0     |
| ■ <u>Specialist copayment</u>          | \$100   |
| ■ Hospital (facility) <u>copayment</u> | \$2,500 |
| ■ Other <u>coinsurance</u>             | 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               |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$0     |
| <u>Copayments</u>          | \$5,000 |
| <u>Coinsurance</u>         | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$60    |
| The total Peg would pay is | \$5,060 |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                        |         |
|----------------------------------------|---------|
| ■ The plan's overall <u>deductible</u> | \$0     |
| ■ <u>Specialist copayment</u>          | \$100   |
| ■ Hospital (facility) <u>copayment</u> | \$2,500 |
| ■ Other <u>coinsurance</u>             | 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               |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$0     |
| <u>Copayments</u>          | \$1,800 |
| <u>Coinsurance</u>         | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$1,820 |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                        |         |
|----------------------------------------|---------|
| ■ The plan's overall <u>deductible</u> | \$0     |
| ■ <u>Specialist copayment</u>          | \$100   |
| ■ Hospital (facility) <u>copayment</u> | \$2,500 |
| ■ Other <u>coinsurance</u>             | 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               |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$0     |
| <u>Copayments</u>          | \$1,800 |
| <u>Coinsurance</u>         | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$0     |
| The total Mia would pay is | \$1,800 |

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):** Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

### العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك