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, please contact Human Resources by calling 262-653-2800. 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 262-653-2800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $2,400 Individual / $4,800 Family; for Non-Network Providers: $4,800 Individual / $9,600 Family; Coinsurance and copayments don't count toward the deductible.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your 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?	Network Providers: $3,400 Individual / $6,800 Family; for Out-of-Network Providers: $6,950 Individual / $13,650 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this Plan, the overall family *out-of-pocket limit* must be met.
What is not included in the out-of-pocket limit?	Premiums, Balance-billing charges, Health care this plan doesn't cover, Penalties, Non-network Transplant.	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. www.humana.com/directories or call 1-866-4ASSIST (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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	30% after deductible	
	Specialist visit	No charge after deductible	30% after deductible	Includes telehealth or telemedicine services
	Preventive care/screening/ immunization	No charge	30% after deductible	- 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. - For Breast Feeding Counseling Non-PAR is No charge - Male Contraceptives and Routine Hearing, Routine Screening Not covered for PAR and Non-PAR.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	30% after deductible	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% after deductible	- Cost share may vary based on where service is performed. - Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.serveyourx.com	Generic drugs (Tier 1)	$12.00 / 30 day supply - after deductible $24.00 / 90 day supply – after deductible	N/A	Prescriptions are processed through Serve Your RX. Telephone #800-759-3203
	Preferred brand drugs (Tier 2)	$35.00 / 30 day supply – after deductible $70.00 / 90 day supply – after deductible	N/A	N/A
	Non-preferred brand drugs (Tier 3)	$60.00 / 30 day supply– after deductible $120.00 / 90 day supply– after deductible	N/A	N/A
	Specialty Drugs	Same as above 100% after deductible	Not covered	Specialty Drugs are limited to Serve You DirectRX Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only
	Physician/surgeon fees	No charge after deductible	30% after deductible	None
If you need immediate medical attention	Emergency room care True Emergency Non-Emergency	No charge after deductible No charge after deductible	No charge after PAR deductible 30% after deductible	None.
	Emergency medical transportation	No charge after deductible	No charge after PAR deductible	None
	Urgent care	No charge after deductible	30% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only
	Physician/surgeon fees	No charge after deductible	30% after deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	30% after deductible	None
	Inpatient services	No charge after deductible	30% after deductible	None
If you are pregnant	Office visits	No charge after deductible	30% after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge after deductible	30% after deductible	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services	No charge after deductible	30% after deductible	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	No charge after deductible	30% after deductible	Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only
	Rehabilitation services	No charge after deductible	30% after deductible	- 15 then pend for medical necessity - Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only
	Habilitation services	No charge after deductible	30% after deductible	- 15 then pend for medical necessity - Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only
	Skilled nursing care	No charge after deductible	30% after deductible	- 180 days per admission - Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only
	Durable medical equipment	No charge after deductible	30% after deductible	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. - Preauthorization may be required - if not obtained, penalty will be $75 Inpatient only
	Hospice services	No charge after deductible	30% after deductible	None
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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	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.)

- Acupuncture, unless it is prescribed by a physician for rehabilitation purposes
- Bariatric Surgery
- Cosmetic Surgery, if to correct a functional impairment
- Dental Care
- Hearing Aids
- Infertility Counseling and Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult), unless for an eye exam
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care – spinal manipulations are covered (Pend for medical necessity after 15 visits)

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:

- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 1-877-267-2323 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.

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:

- Your plan at calling 262-653-2422
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-4ASSIST (427-7478).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-4ASSIST (427-7478).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-4ASSIST (427-7478).

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	$2,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	**$2,430**

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

The plan's overall deductible	$2,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$4,100**

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

The plan's overall deductible	$2,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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