Medical and Vision Plan Benefits

Living what matters

City of Miami Springs

Humana®

GCHJYGLEN 0719

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 1-866-4ASSIST (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 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 Individual / $3,000 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?	Yes. Certain Office Visits, Preventive, Emergency Room Care, Urgent Care, Prescription Drugs and Certain Therapies	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?	$5,000 individual / $10,000 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	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 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)	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: $25 copay/office visit; deductible does not apply Primary care visit: $25 copay/office visit; deductible does not apply	Not Covered	None
	Specialist visit	$50 copay/visit; deductible does not apply	Not Covered	None
	Preventive care / screening / immunization	No charge; deductible does not apply	Not Covered	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; deductible does not apply	Not Covered	Cost sharing may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	$300 copay; deductible does not apply	Not Covered	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at** https://www.humana.com/2020-Rx4-FL	Level 1 - Low-cost generic and brand-name drugs	(Retail) $10 copay; deductible does not apply (Mail Order) $25 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	(Retail) 30 day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug (Mail) 90 day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug
	Level 2 - Higher-cost generic and brand-name drugs	(Retail) $40 copay; deductible does not apply (Mail Order) $100 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	

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 3 - High-cost, mostly brand-name drugs	(Retail) $70 copay; deductible does not apply (Mail Order) $175 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	
	Level 4 - Highest-cost drugs	(Retail) 25% coinsurance; deductible does not apply (Mail Order) 25% coinsurance; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	
	Specialty Drugs	Preferred network specialty pharmacy: 25% coinsurance; deductible does not apply Network specialty pharmacy: 35% coinsurance; deductible does not apply	Not Covered	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)	No charge after deductible	Not Covered	None
	Physician/surgeon fees	No charge after deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	$350 copay/visit; deductible does not apply	$350 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted
	Emergency medical transportation	No charge after deductible	No charge after deductible	
	Urgent care	$75 copay/visit; deductible does not apply	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not Covered	None
	Physician/surgeon fees	No charge after deductible	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)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $25 copay/visit Other outpatient services: No charge; deductible does not apply	Not Covered	None
	Inpatient services	No charge after deductible	Not Covered	None
If you are pregnant	Office visits	No charge; deductible does not apply	Not Covered	Office visits: Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge after deductible	Not Covered	Childbirth/delivery professional services: Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services.	No charge after deductible	Not Covered	Childbirth/delivery facility services: 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	Not Covered	100 visits per year
	Rehabilitation services	Physical, occupational, speech, cognitive, audiology therapy and manipulations: $50 copay/visit; deductible does not apply	Not Covered	Therapies: Physical, occupational, speech, cognitive, audiology therapy and manipulations: 30 visits per year combined
	Habilitation services	Physical, occupational, speech, audiology therapy and manipulations: $50 copay/visit; deductible does not apply	Not Covered	

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)	
	Skilled nursing care	No charge after deductible	Not Covered	60 days per year
	Durable medical equipment	No charge after deductible	Not Covered	Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice services	No charge after deductible	Not Covered	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
	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 other excluded services.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture, if it is prescribed by a physician
- Chiropractic care - spinal manipulations are covered
- Cosmetic surgery, if to correct a functional impairment
- 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 1-866-4ASSIST (427-7478).
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 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. 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 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Florida Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399-0322, Phone: 850-413-3140 or 877-693-5236.

Does this plan provide Minimum Essential Coverage? **Yes.**

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

Does this plan meet Minimum Value Standards? **Yes.**

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478) (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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** **$1,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,530**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **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	**$7,400**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$700
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 Notice:

Florida Compare Care resources from the Agency for Health Care Administration (AHCA) can be found at http://www.floridahealthfinder.gov/. The site includes helpful information about Florida healthcare, plans and facilities.

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 identity, or religion. 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 **1-866-427-7478** 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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-866-427-7478 (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. 1-866-427-7478 (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

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 1-866-4ASSIST (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 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 Individual / $1,500 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?	Yes. Certain Office Visits, Preventive, Emergency Room Care, Urgent Care, Prescription Drugs and Certain Therapies	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?	$2,250 individual / $5,500 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	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 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)	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: $25 copay/office visit; deductible does not apply Primary care visit: $25 copay/office visit; deductible does not apply	Not Covered	None
	Specialist visit	$50 copay/visit; deductible does not apply	Not Covered	None
	Preventive care / screening / immunization	No charge; deductible does not apply	Not Covered	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; deductible does not apply	Not Covered	Cost sharing may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Not Covered	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at** https://www.humana.com/2020-Rx3-FL	Level 1 - Generic drugs	(Retail) $10 copay; deductible does not apply (Mail Order) $25 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	(Retail) 30 day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug (Mail) 90 day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug
	Level 2 - Preferred brand-name drugs	(Retail) $35 copay; deductible does not apply (Mail Order) $87.50 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	

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 3 - Higher-cost brand-name drugs	(Retail) $60 copay; deductible does not apply (Mail Order) $150 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	
	Specialty Drugs	$200 copay; deductible does not apply	Not Covered	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)	No charge after deductible	Not Covered	None
	Physician/surgeon fees	No charge after deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted
	Emergency medical transportation	No charge after deductible	No charge after deductible	
	Urgent care	$50 copay/visit; deductible does not apply	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not Covered	None
	Physician/surgeon fees	No charge after deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $25 copay/visit Other outpatient services: No charge; deductible does not apply	Not Covered	None
	Inpatient services	No charge after deductible	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)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge; deductible does not apply	Not Covered	Office visits: Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge after deductible	Not Covered	Childbirth/delivery professional services: Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services.	No charge after deductible	Not Covered	Childbirth/delivery facility services: 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	Not Covered	100 visits per year
	Rehabilitation services	Physical, occupational, speech, cognitive, audiology therapy and manipulations: $50 copay/visit; deductible does not apply	Not Covered	Therapies: Physical, occupational, speech, cognitive, audiology therapy and manipulations: 60 visits per year combined
	Habilitation services	Physical, occupational, speech, audiology therapy and manipulations: $50 copay/visit; deductible does not apply	Not Covered	
	Skilled nursing care	No charge after deductible	Not Covered	60 days per year
	Durable medical equipment	No charge after deductible	Not Covered	Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice services	No charge after deductible	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)	Non-Network Provider (You will pay the most)	
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 other excluded services.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Hearing aids
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- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
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- Routine foot care
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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
- Chiropractic care - spinal manipulations are covered
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- Dental care (Adult), if for dental injury of a sound natural tooth

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- www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Florida Office of Insurance Regulation: 1-877-693-5236 (in-state) or 850-413-3089 (out-of-state) or www.floir.com.

Does this plan provide Minimum Essential Coverage? **Yes.**

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

Does this plan meet Minimum Value Standards? **Yes.**

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478) (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**0%**
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$830**

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

The plan's overall deductible	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**0%**
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,400**

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

The plan's overall deductible	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**0%**
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

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 1-866-4ASSIST (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 1-866-4ASSIST (427-7478) 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. Certain Office Visits, Preventive, Emergency Room Care, Urgent Care, Prescription Drugs and Certain Therapies	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?	$1,500 individual / $3,000 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	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 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)	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: $15 copay/office visit; deductible does not apply Primary care visit: $15 copay/office visit; deductible does not apply	Not Covered	None
	Specialist visit	$15 copay/visit; deductible does not apply	Not Covered	None
	Preventive care / screening / immunization	No charge; deductible does not apply	Not Covered	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; deductible does not apply	Not Covered	Cost sharing may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	No charge	Not Covered	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at** https://www.humana.com/2020-Rx3-FL	Level 1 - Generic drugs	(Retail) $10 copay; deductible does not apply (Mail Order) $20 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	(Retail) 30 day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug (Mail) 90 day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug
	Level 2 - Preferred brand-name drugs	(Retail) $35 copay; deductible does not apply (Mail Order) $70 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	

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 3 - Higher-cost brand-name drugs	(Retail) $50 copay; deductible does not apply (Mail Order) $100 copay; deductible does not apply	(Retail) Not Covered (Mail Order) Not Covered	
	Specialty Drugs	$200 copay; deductible does not apply	Not Covered	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)	No charge after deductible	Not Covered	None
	Physician/surgeon fees	No charge after deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	$50 copay/visit; deductible does not apply	$50 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted
	Emergency medical transportation	No charge after deductible	No charge after deductible	
	Urgent care	$25 copay/visit; deductible does not apply	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission; deductible does not apply	Not Covered	None
	Physician/surgeon fees	No charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $15 copay/visit Other outpatient services: No charge; deductible does not apply	Not Covered	None
	Inpatient services	$500 copay/admission; deductible does not apply	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)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	Not Covered	Office visits: Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	Not Covered	Childbirth/delivery professional services: Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services.	$500 copay/admission; deductible does not apply	Not Covered	Childbirth/delivery facility services: 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	Not Covered	100 visits per year
	Rehabilitation services	Physical, occupational, speech, cognitive, audiology therapy and manipulations: $15 copay/visit; deductible does not apply	Not Covered	Therapies: Physical, occupational, speech, cognitive, audiology therapy and manipulations: 60 visits per year combined
	Habilitation services	Physical, occupational, speech, audiology therapy and manipulations: $15 copay/visit; deductible does not apply	Not Covered	
	Skilled nursing care	$500 copay/admission; deductible does not apply	Not Covered	60 days per year
	Durable medical equipment	No charge after deductible	Not Covered	Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice services	No charge after deductible	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)	Non-Network Provider (You will pay the most)	
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 other excluded services.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture, if it is prescribed by a physician
- Chiropractic care - spinal manipulations are covered
- Cosmetic surgery, if to correct a functional impairment
- Dental care (Adult), if for dental injury of a sound natural tooth

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- www.humana.com or 1-866-4ASSIST (427-7478).
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 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. 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 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
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Does this plan provide Minimum Essential Coverage? **Yes.**

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

Does this plan meet Minimum Value Standards? **Yes.**

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

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

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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) coinsurance	**0%**
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	**$12,800**

In this example, Peg would pay:

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

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) coinsurance	**0%**
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

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

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**0%**
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

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 1-866-4ASSIST (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 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $750 Individual / $1,500 family; Non-Network: $1,500 Individual / $3,000 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: Yes. Certain Office Visits, Preventive, Emergency Room Care, Urgent Care, Prescription Drugs and Certain Therapies Non-Network Providers: Yes. Emergency Room Care and Prescription Drugs	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 $2,750 individual / $5,500 family For non-network providers $5,500 individual / $11,000 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, Non-network transplant, non-network prescription drugs, non-network specialty drugs	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 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)	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: $20 copay/office visit; deductible does not apply Primary care visit: $20 copay/office visit; deductible does not apply	Telehealth or telemedicine services: 40% coinsurance Primary care visit: 40% coinsurance	None
	Specialist visit	$20 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care / screening / immunization	No charge; deductible does not apply	40% 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; deductible does not apply	40% coinsurance	Cost sharing may vary based on where service is performed. Imaging: Preauthorization may be required - if not obtained, penalty will be 50%
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

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 need drugs to treat your illness or condition **More information about prescription drug coverage is available at** https://www.humana.com/2020-Rx3-FL	Level 1 - Generic drugs	(Retail) $10 copay; deductible does not apply (Mail Order) $25 copay; deductible does not apply	(Retail) 30% coinsurance, after $10 copay; deductible does not apply (Mail Order) 30% coinsurance, after $25 copay; 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) 90 day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug
	Level 2 - Preferred brand-name drugs	(Retail) $35 copay; deductible does not apply (Mail Order) $87.50 copay; deductible does not apply	(Retail) 30% coinsurance, after $35 copay; deductible does not apply (Mail Order) 30% coinsurance, after $87.50 copay; deductible does not apply	
	Level 3 - Higher-cost brand-name drugs	(Retail) $60 copay; deductible does not apply (Mail Order) $150 copay; deductible does not apply	(Retail) 30% coinsurance, after $60 copay; deductible does not apply (Mail Order) 30% coinsurance, after $150 copay; deductible does not apply	
	Specialty Drugs	$200 copay; deductible does not apply	50% coinsurance; deducible 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)	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

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 need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay/visit; deductible does not apply	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $20 copay/visit; deductible does not apply Other outpatient services: No charge; deductible does not apply	Therapy: 40% coinsurance Other outpatient services: 40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Inpatient services: Preauthorization may be required - if not obtained, penalty will be 50%
If you are pregnant	Office visits	No charge; deductible does not apply	40% coinsurance	Office visits: Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Childbirth/delivery professional services: Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services.	20% coinsurance	40% coinsurance	Childbirth/delivery facility services: Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). 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)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits per year Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	Physical, occupational, speech, cognitive, audiology therapy and manipulations: $20 copay/visit; deductible does not apply	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 40% coinsurance	Therapies: Therapies: Preauthorization may be required - if not obtained, penalty will be 50% Physical, occupational, speech, cognitive, audiology therapy and manipulations: 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, occupational, speech, audiology therapy and manipulations: $20 copay/visit; deductible does not apply	Physical, occupational, speech, audiology therapy and manipulations: 40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days per year Preauthorization may be required - if not obtained, penalty will be 50%
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50% Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice services	20% coinsurance	40% coinsurance	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)	
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 other excluded services.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture, if it is prescribed by a physician
- Chiropractic care - spinal manipulations are covered
- Cosmetic surgery, if to correct a functional impairment
- Dental care (Adult), if for dental injury of a sound natural tooth

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- www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Florida Office of Insurance Regulation: 1-877-693-5236 (in-state) or 850-413-3089 (out-of-state) or www.floir.com.

Does this plan provide Minimum Essential Coverage? **Yes.**

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

Does this plan meet Minimum Value Standards? **Yes.**

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478) (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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	**$750**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,820**

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

The plan's overall deductible	**$750**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

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

The plan's overall deductible	**$750**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

Quick-start member guide

GETTING STARTED IS AS EASY AS 1-2-3

1

Register for MyHumana

Start by creating an account at **MyHumana.com** or downloading the MyHumana Mobile app on your smartphone. It's all your plan information in one place.

2

Get your Humana member ID card

You can view, print or email your Humana member ID card at MyHumana. It's available within 10 working days of enrollment. (We also mail your medical card to your home address.)

3

Find your doctor

At MyHumana, you can see if your doctor, hospital or clinic is in your plan's network. Or, if you need a doctor, you can easily find one.

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GCHK5BEEN 1218

Enrollment Guide

Additional benefits

Preventive care covered at no additional cost when you use in-network providers

Humana Pharmacy®
Save money and time with our full-service, mail-delivery pharmacy for your regular or specialty prescription needs.

Go365® wellness program
Get rewarded with things like Amazon and Target gift cards for doing the everyday things that help keep you healthy.

Doctor On Demand®
See a doctor from anywhere, anytime using your computer or mobile device. Board-certified doctors can diagnose conditions like the flu, strep throat and urinary tract infections and may write you a prescription and get you feeling better without the need to go in to an office.

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HUMANA PHARMACY® MOBILE APP MAKES REFILLS A SNAP

The freedom to manage your prescriptions anytime, anywhere

With a simple download, you have the power to stay on track with your medicines and your best health. It's quick, easy and user-friendly.

eHealthcare LEADERSHIP AWARDS 2017 WINNER

AWARDED THE 2017 PLATINUM AWARD FOR "BEST MOBILE APP & SITES" AT THE HEALTHCARE INTERNET CONFERENCE

For Humana members

REFILL
Take a photo of your pill bottle and we'll contact your doctor for a refill

REVIEW
Enhanced order status display for at-a-glance shipment tracking

RELAX
Reliable refill reminders and status updates keep you on track

DOWNLOAD NOW
Download the free Humana Pharmacy mobile app today. Available on iOS and Android devices.

Humana Pharmacy®

Download on the App Store

GET IT ON Google Play

GNHK3D5EN 1017 3271ALL1217

HUMANA PHARMACY PRESCRIPTIONS TO YOUR DOOR

More convenience, less hassle

Prescription mail delivery for 90-day traditional drugs or specialty drugs means fewer trips to the pharmacy, and more time for you!

SUBMIT YOUR PRESCRIPTIONS ANY WAY YOU LIKE

MOBILE APP

Order and tracking at your fingertips

THE WEB

Sign up at **huma.na/RxApp**

CALL US

Humana Pharmacy
1-800-379-0092
(TTY: 711)

Humana Specialty Pharmacy®
1-800-486-2668

Discrimination is against the law

Humana Pharmacy, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-379-0092 (TTY: 711)**.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-379-0092 (TTY: 711)**.

繁體中文(Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-379-0092 (TTY: 711)** 。

Humana Pharmacy®

DOWNLOAD THE HUMANA PHARMACY MOBILE APP FOR IOS AND ANDROID

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Quality care that's virtually there 24/7

Doctor On Demand® is there for your everyday health needs

See a **board-certified doctor**—for nonemergency care—in minutes from your home, office or while you're traveling in the United States, from your smartphone, tablet or computer. It's easy.

For everyday health needs, Doctor On Demand usually costs less than a visit to the emergency room or urgent care.

DOCTOR ON DEMAND	COST
Everyday health concerns • Colds, flu and sore throat • Upper respiratory infections • Skin and eye problems • Urinary tract infections • Prescriptions and refills • Labs and screenings	**$0–$56**
Mental health services • Depression • Stress • Anxiety • Trauma • Other nonemergency mental health concerns	The same cost as an in-office mental health visit

Download the Doctor On Demand app today

1. Go to the App store or Google Play to get it on your smartphone or tablet. You can also visit DoctorOnDemand.com.
2. Enter your health insurance information; select Humana and enter your group ID and member ID.
3. Enter a payment method (you'll always see your cost upfront).
4. See a doctor within minutes.

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Pricing is subject to change without notice. Doctor On Demand services are not available for Humana members in Puerto Rico and outside the U.S. This document is a general description of the identified benefits. The actual plan document will determine the benefit available to you. If there is disagreement between this general description and the plan document, the plan document will control. Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services is for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

GCHJWKFEN 0220

Plan ahead with the convenient care options your plan provides

Know when and where to go

When you have to make a healthcare decision, make sure you're ready. Review some of the choices of care that are available so you can decide where to go the next time you need treatment.

Doctor's office

Take advantage of the relationship you have with your doctor. Calling your doctor's office during business hours is your best option for treatment in nonemergency situations.

Virtual visits (Telemedicine)

Virtual visits with board-certified doctors, for nonemergency conditions, 24/7 with Doctor On Demand®.* If you have telemedicine benefits as part of your Humana plan, you may be able to connect with a U.S board-certified doctor within minutes from the comfort of your own home, office or while traveling. The technology is HIPAA-compliant and most prescriptions may be sent to the pharmacy of your choice. Telemedicine may be an affordable and convenient option.** Doctor On Demand also provides nonemergency psychiatric and therapy services and treatment for anxiety, depression, grief, addictions and other behavioral health conditions. **Behavioral health visits are by scheduled appointment only.**

Retail health clinic

When you can't see your doctor, a retail clinic can help you with minor problems like a cold, earache or sore throat. Retail clinics are conveniently located at stores, such as CVS®, Target®, Kroger® and Walgreens. Check to see which retail clinics are available in your network.

Urgent care center

When you have a minor illness or injury and your doctor isn't available, you might consider going to an urgent care center. Waiting periods are usually shorter than in an emergency room. Many centers have X-ray and lab services and are open in the evenings and on weekends.

Emergency room (ER)

Visit the ER for a serious medical situation that might represent a threat to your life or limbs. It's generally appropriate for situations like uncontrolled bleeding, chest pain, difficulty breathing and possible stroke.

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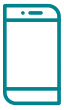
Decide where to seek medical care

Condition	Doctor's office	Virtual visits	Retail health clinic	Urgent care center
Minor headache	✓	✓	✓	✓
Minor sprain, strain	✓	✓		✓
Nausea, vomiting, diarrhea	✓	✓		✓
Bumps, cuts, scrapes	✓	✓	✓	✓
Cough, sore throat, congestion	✓	✓	✓	✓
Urinary burning	✓	✓	✓	✓

Emergency room

Generally, you should call 911 or go to the emergency room for the following type of symptoms or any symptom that you feel may represent a threat to your life or limbs.

- Sudden or unexplained loss of consciousness
- Signs of a heart attack, such as sudden/severe chest pain or pressure
- Signs of a stroke, such as numbness of the face, arm or leg on one side of the body; difficulty talking; sudden loss of vision
- Severe shortness of breath
- Coughing up or vomiting blood
- High fever with stiff neck, mental confusion and/or difficulty breathing
- Cut or wound that won't stop bleeding
- Possible poisoning
- Possible broken bones
- Stab wounds
- Sudden, severe abdominal pain
- Suicidal feelings
- Partial or total amputation of a limb



Ensure a provider participates in the Humana network by going to **Humana.com** or using the MyHumana Mobile app on your mobile device.

*Your plan's provider network may designate a virtual visit provider other than Doctor On Demand.
**Doctor On Demand services are not available for Humana members in Puerto Rico and outside the U.S.

Limitations on healthcare and prescription services delivered via telemedicine and communications options vary by state. Telemedicine is not a substitute for emergency care. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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Preventive services guide

Humana makes it easier than ever to get the preventive services you need to maintain your overall health. As part of healthcare reform—and depending on your Humana health plan—a range of preventive services will be available to you at no cost.

The services listed here will be covered 100 percent when they're provided for preventive care. This means no copayments, coinsurance or deductible when services are performed by providers in the Humana network.

Note: You may need to pay all or part of the costs when services are completed to diagnose, monitor or treat an illness, pregnancy or injury, rather than prevent an illness, pregnancy or injury.

Adult preventive services

Preventive office visits are covered, as well as the screenings, immunizations and counseling listed below.

Screenings	
Abdominal aortic aneurysm	One time screening for men of specified ages who have ever smoked
Alcohol misuse	Screening and counseling for all adults
Blood pressure	Screening for high blood pressure for all adults
Cholesterol	Screenings for adults certain ages or at higher risk[1]
Colorectal cancer	Screening for adults at 50–75
Depression	Screening for all adults
Diabetes	Screening for adults 40–70 at higher risk[1]
Hepatitis B	Screening for all adults at higher risk[1]
Hepatitis C	Screening for adults at higher risk[1] or one-time screenings for adults born 1945–1965
HIV	Screening for all adults at higher risk[1]
Lung cancer	Annual screenings for adults at all specified ages who smoke or have quit within the past 15 years
Obesity	Screening for all adults
Syphilis	Screening for all adults at higher risk[1]
Tobacco use	Screening for all adults and cessation interventions for tobacco users
Tuberculosis	Screening for latent infection for adults at higher risk[1]

Medications and supplements (covered with a doctor's prescription)	
Aspirin	Use of aspirin to prevent cardiovascular disease for women and men at specified ages
Colonoscopy preparation	Bowel preparation medications for adults age 50–75
Smoking cessation	Over-the-counter and prescription smoking cessation medications for members 18 years and older
Statin	Low- to moderate-dose statin use for adults 40–75 at higher risk[1]
Vitamin D	Supplementation to prevent falls in community dwelling for adults age 65 and older at increased risk for falls

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[1]For more information on the definition of "higher risk" and age recommendations, please go to the US Preventive Guidelines at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

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Adult preventive services continued

Preventive office visits are covered, as well as the screenings, immunizations and counseling listed below.

Counseling	
Healthy diet and physical activity	Counseling to prevent cardiovascular disease for adults who have cardiovascular risk factors or higher risk for chronic disease[1]
Obesity	Referral to intensive, multicomponent behavioral interventions for patients with a body mass index (BMI) of 30 kg/m or higher
Sexually transmitted infection (STI)	Prevention counseling for adults at higher risk[1]

Other	
Exercise or physical therapy	Fall prevention for adults age 65 or older at increased risk for falls
Skin cancer	Brief counseling for young adults through age 24 to minimize their exposure to ultraviolet radiation

Preventive care keeps you healthy, prevents illness and detects disease in the early stages when it is easier to treat.

Immunizations

(vaccines for adults—doses, recommended ages and recommended populations vary)[2]

- Chickenpox/varicella
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Influenza
- Measles, mumps, rubella (MMR)
- Meningococcal
- Pneumococcal
- Shingles/herpes zoster
- Tetanus, diphtheria, pertussis (Tdap)

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[1]For more information on the definition of "higher risk" and age recommendations, please go to the US Preventive Guidelines at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

[2]For more information on immunization recommendations, resources and schedules, please refer to the Centers for Disease Control and Prevention at www.cdc.gov/vaccines/schedules/index.html

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Women preventive services (includes pregnant women)

Preventive office visits are covered, as well as the screenings and counseling listed below.

Counseling

Genetic counseling for women who have tested positive for BRCA

Breast cancer chemoprevention
Counseling for women at increased risk for breast cancer

Domestic and interpersonal violence
Screenings and referral for intervention services

Tobacco use counseling for pregnant women
Behavioral interventions for cessation

Other Services

Aspirin to prevent preeclampsia
Low-dose aspirin after 12 weeks of gestation in women who are at high risk[1]

Breastfeeding[3]
Equipment and counseling to promote Breastfeeding during pregnancy and in the postpartum period

Contraceptive methods and counseling[3]

Screenings

Anemia	Screening on a routine basis for pregnant women
Bacteriuria	Urinary tract or other infection screening for pregnant women
BRCA	Screenings for women at higher risk[1]
Breast cancer mammography	Screenings every 1–2 years for women age 40 or over
Cervical cancer	Screening for women with a cervix, regardless of sexual history, at specified ages and intervals[4]
Chlamydia infection	Screening for younger women and other women at higher risk[1]
Depression	Screening for pregnant and postpartum women
Gestational diabetes	Screenings for women after 24 weeks of gestation
Gonorrhea	Screening for all women at higher risk[1]
Hepatitis B	Screening for younger women and other women at higher risk[1]
HIV	Screenings for pregnant women
HPV-DNA test	High risk testing every 3 years for women with normal cytology results who are age 30 or older[1]
Osteoporosis (bone density)	Screening for women age 65 and over and women at higher risk[1]
Preeclampsia	Screening for all pregnant women
Rh incompatibility	Screening for all pregnant women during their first prenatal visit and at 24–28 weeks gestation
Syphilis	Screening for all pregnant women or other women at higher risk
Tobacco use	Screening and interventions for all women, and expanded counseling for pregnant tobacco users

Medications and supplements (covered with a doctor's prescription)

Aspirin	Low-dose medication for women for prevention of preeclampsia
Breast cancer preventive medications	For women at increased risk for breast cancer
Contraception	FDA-approved contraceptives for women with reproductive capacity to prevent pregnancy
Prenatal vitamins/ folic acid	For women who are, may become pregnant or are capable of pregnancy

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[1]For more information on the definition of "higher risk" and age recommendations, please go to the US Preventive Guidelines at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

[3]On Aug. 1, 2011, the U.S. Department of Health and Human Services released new guidelines regarding coverage of preventive health services for women. The new guidelines state that non-grandfathered insurance plans with plan years beginning on or after Aug. 1, 2012, must include these services without cost sharing.

[4]Women 21–65: with cytology (Pap test) every three years; women 30–65: wanting to lengthen the screening interval.

We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan. For complete details, refer to your plan's Certificate of Coverage.

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Child preventive services

Preventive office visits are covered, as well as the screenings, immunizations, counseling and supplements listed below.

Immunizations

(vaccines for children from birth to age 18, doses, ages and populations vary)[2]

- Chickenpox/varicella
- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Inactivated poliovirus
- Influenza
- Measles, mumps, rubella (MMR)
- Meningococcal
- Pneumococcal
- Rotavirus
- Tetanus, pertussis, diphtheria (Tdap)

Counseling

Obesity
Referral to intensive behavioral interventions to promote improvements in weight status

Sexually transmitted infection (STI)
Prevention counseling for adolescents at higher risk[1]

Skin cancer
Brief counseling for young adults age 10–24 years old to minimize their exposure to ultraviolet radiation

Tobacco use
Education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents

Screenings

Alcohol and drug use	Assessments for adolescents
Autism	Screening for children at 18–24 months
Behavioral	Assessments for children of all ages
Depression	Screening for adolescents
Developmental	Screening for children under age 3, and surveillance throughout childhood
Dyslipidemia	Screening for children at higher risk[1] of lipid disorders
Height, weight and body mass index	Measurements for children of all ages
Hemoglobinopathies	Screening for sickle cell disease in newborns
Hepatitis B	Screening for adolescents at higher risk[1]
Hypothyroidism	Screening for newborns
HIV	Screening for adolescents at higher risk[1]
Lead	Screening for children at risk of exposure
Medical history	For all children throughout development
Obesity	Screening for children age 6 or older
Oral health	Risk assessment for young children
Phenylketonuria (PKU)	Screening for newborns
Sexually transmitted infection	Screening for adolescents at higher risk[1]
Tuberculin	Testing for children at higher risk[1] of tuberculosis
Vision	Screening for all children between the ages 3–5 years old

Medications and supplements (covered with a doctor's prescription)

Fluoride chemoprevention	Supplements starting at age 6 months for children without fluoride in their water sources
Fluoride varnish	Application by a primary care clinician to primary teeth starting at tooth eruption up to age 5
Gonorrhea	Preventive medicine for the eyes of all newborns
Iron	Supplements for children ages 6–12 months at risk for anemia

Refer to your Certificate of Coverage for details about all the covered services and benefit levels.

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[1]For more information on the definition of "higher risk" and age recommendations, please go to the US Preventive Guidelines at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

[2]For more information on immunization recommendations, resources and schedules, please refer to the Centers for Disease Control and Prevention at www.cdc.gov/vaccines/schedules/index.html

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EAP and Work-Life Services

Your company understands that job satisfaction and higher productivity are best achieved when employees' personal needs are being met, and when their work and personal lives are in balance. That's why your company offers you EAP and Work-Life – to help you meet your unique personal needs and life events.

What is an EAP?

An Employee Assistance Program (EAP) offers support and referral to the most appropriate resources over the telephone to help you and members of your household manage everyday life issues. EAP professionals are available to assist you with:

- Everyday needs and life events
- Weight control
- Emotional issues
- Relationship concerns
- Family relationships
- Coping with a serious illness
- Sleeping difficulties
- Loss of a loved one
- Eating disorders
- Workplace concerns
- Smoking cessation

What is Work-Life?

Work-Life offers extensive assistance, information, and support to help you achieve a better balance between work, life, and family to help make your life easier. You can access information and self-search locators to find resources and providers that can help you with:

- Convenience services
- Housing options
- Child care
- Financing college
- Home ownership
- Caregiving from a distance
- Moving and relocation
- Finding colleges and universities
- Services and education for children with special needs
- Adoption, pregnancy and infertility
- Adjusting to retirement
- Locating services and care for older adults
- Pet care
- Finding schools
- Tutors and test prep
- Child development
- Recreational activities
- Consumer education

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What is the Legal and Financial Program?

As part of the EAP, you also have access to a free 30-minute consultation with a local attorney or financial counselor on issues such as real estate, retirement planning, divorce and separation, budgeting/debt reconstruction, and trusts and estates. Further legal and tax preparation services are discounted 25 percent.

What if I'm just looking for information?

You can access many useful articles, tip sheets, and checklists by calling or signing in to the EAP and Work-Life website. Many helpful topics are available, including relationships, communication, life in the workplace, and emotional well-being.

What else does the website offer?

It includes dozens of locators that allow you to search for health and wellness information, child care providers, adoption services, schools and colleges, daily living needs, older adult care, and much more. The site also offers calculators that can help you with everything from mortgage payment calculations to how much to save for your children's college education.

Who can use EAP and Work-Life?

All employees and household members.

Are these services confidential?

Yes. EAP and Work-Life are confidential according to law.

Who pays for these services?

Your company pays all costs when you and members of your household use the program. If additional assistance or services are needed, you will receive referrals that consider your preferences, medical plan, and financial circumstances. Please refer to your insurance plan booklet or your Human Resources department for specific information about your medical plan.

How do I access these services?

EAP and Work-Life are convenient, confidential and provided at no cost to you and members of your household. We're here 24 hours, seven days a week, so call or sign in anytime using the information provided below.

LIFE MADE EASIER.

FOR FREE, CONFIDENTIAL EAP ASSISTANCE,

Call: 1-866-440-6556 TTY: 711
Sign in: Humana.com/eap
Username: eapt
Password: eapt

Humana.

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Services provided by Humana EAP and Word-Life Services. Personal information about participants and members of their households remains confidential according to all applicable state and federal laws. Information may be disclosed if permitted by such laws.

Free legal/financial consultations are limited to 30 minutes per issue. A 25 percent discount on further legal and tax preparation services provided by attorneys, mediators, and financial counselors is available. Certain legal and financial topics and issues are excluded from this service.

It is important that we treat you fairly. Discrimination is against the law. Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana complies with all Federal and State Civil Rights laws.

Language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).
Español: Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文: 撥打上面的電話號碼即可獲得免費語言援助服務。

Say hello to Go365.

It's your personalized wellness and rewards program.

Getting healthier is easier – and lots more fun – with Go365™. When it comes to health and wellness, you have your own approach. One that works for you. Go365 makes it easier to get moving along your path with more ways to start, more Activities to unlock, and more ways to rack up rewards.

Unlock Activities.

Go365 is all about you. You'll receive Activities personalized to help you reach your health goals, no matter where you are on your journey to better health. Just unlock your Activities and earn Points for higher Status.

Stay inspired.

Getting healthier can be hard. Go365 makes it easier by connecting you to all the tools and resources you need to get there. Tracking your activity is a breeze – just connect your compatible apps or fitness devices and earn Points for all your healthy activities.

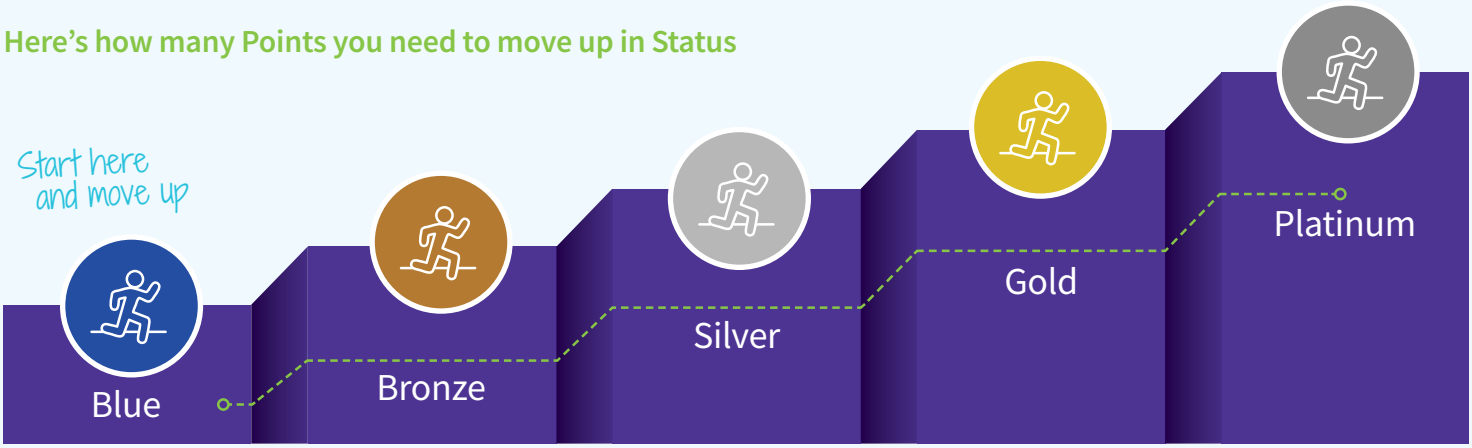
Earn rewards.

Making healthier choices is a lot more fun with Go365. The more you move up in Status, the more Bucks you can earn and spend on great items in the Go365 Mall. Plus, Bonus Bucks, surprise rewards, and monthly Jackpot drawings make getting healthy more fun!

More Points. Higher Status.

Earning Points pays off big with higher Status levels. Get your spouse and kids involved too and see how fast you can move up in Status.

Here's how many Points you need to move up in Status



3 ways to get to Bronze

1. Complete at least one Health Assessment section online or on the Go365 App
2. Get a Biometric Screening
3. Log a verified workout

Blue	Bronze	Silver	Gold	Platinum
5,000 One adult per policy	8,000 One adult per policy	10,000 One adult per policy		
8,000 **combined** two adults per policy	12,000 **combined** two adults per policy	15,000 **combined** two adults per policy		
+3,000 for each member 18 years and older per policy	+4,000 for each member 18 years and older per policy	+5,000 for each member 18 years and older per policy		

Adult children can only move a family to Bronze Status by completing a verified workout.

ANDROID APP ON Google play

Download on the App Store

Go365.com

GET REWARDED WITH Go365!

SEE HOW FAST YOU CAN REDEEM REWARDS IN THE Go365 MALL

As a Go365® member, you earn Points for completing healthy activities. You get 1 Buck for each Point you earn, plus Bonus Bucks when you reach a higher Status. These Bucks add up for you to spend in the Go365 Mall on products from popular brands and retailers. Visit the Go365 Mall online or on the Go365 App to see all the great products, deals and offers.

Popular brands

E-GIFT CARDS

Rewards start at 2,000 Bucks ($20 value)

amazon · TARGET · LOWE'S · BEST BUY · FANDANGO

Rewards start at 1,200 Bucks ($12 value)

FITNESS DEVICES AND GEAR

Rewards start at 2,500 Bucks (Garmin Vivoki & Fitbit Zip)

GARMIN · fitbit · TREK · CAMELBAK

Deals and offers

FITRADIO

THE BIGGEST LOSER RESORT

Rock 'n' Roll MARATHON SERIES®

priceline partner network.com™

Bucks cannot be used on discounts. Discounts must be purchased with a credit or debit card. Merchandise subject to availability and may change without notice.

Charities

Rewards start at 1,000 Bucks ($10 donation)

FEEDING AMERICA

American Cancer Society®

American Diabetes Association.

American Heart Association.

American Red Cross

easterseals taking on disability together

National Park Foundation.

Members must have at least Bronze Status to spend Bucks in the Go365 Mall. Only the primary Go365 member can spend Bucks in the Mall.

Visit the Mall online or on the App to find all the rewards you can earn for living healthier

Get Go365 support at **community.Go365.com**

Go365 is not an insurance product. Not available with all Humana health plans.

The merchants represented are not sponsors of Go365 or otherwise affiliated with Go365. The logos and other identifying marks attached are trademarks of and owned by each represented company and/or its affiliates. Please visit each company's website for additional terms and conditions.

Bucks must be redeemed within three years following the year they are earned. This means that unused Bucks earned anytime in year 1 will expire on the last day of year 4.

GCHJMHREN 0218

HAVE FUN. SAVE MONEY. EAT HEALTHY.

Play Pick 6

Save up to 50% on Great For You™ healthier foods at Walmart®.

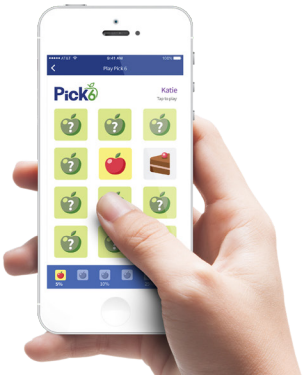
go365™

HealthyFood. Healthy Savings.

As a Go365™ member eligible for HealthyFood, use your HealthyFood Shopping Card to save* 5% on all Great For You healthier foods at Walmart. Play Pick 6 online or on the Go365 App for a chance to win up to 50% savings, every month!

Look for qualifying items with the Great For You icon on products including fresh and canned fruits and vegetables, low-fat dairy, lean meats and some whole-grain products.

Play. Pick. Win.



- Tap six squares — the more apples you reveal, the bigger your discount — up to 50% each month
- Play early in the month — the discount you win is good for the entire month
- Your discount will be available two business days after you play Pick 6
- If you skip Pick 6 for a month, you'll get the standard 5% discount as long as you maintain Bronze Status or higher and you haven't reached the maximum $600 annual savings limit

What — no HealthyFood Shopping Card?

Let's fix that fast. After you reach Bronze Status or higher, request your Shopping Card via **Go365.com** or the App.

Go365 is not an insurance product. Not available with all Humana health plans.

Go365 members must have Bronze Status or higher and must be 18 years of age or older to be eligible to participate in HealthyFood. HealthyFood is not available to all Go365 members and is only available with certain plans or products offered by Humana. To check your Status or see if you are eligible for HealthyFood, sign in to your Go365.com account. For a listing of all qualifying Great For You healthier food items, visit the HealthyFood page on Go365.com or check Walmart.com. HealthyFood is only available at Walmart Neighborhood Markets and Walmart retail stores. Sam's Club stores and Walmart.com are excluded from HealthyFood.

*Standard program savings on Great For You healthier foods is 5%. Any increase in savings is variable and based on an eligible member playing the HealthyFood Pick 6 game. For complete Pick 6 game details, see Frequently Asked Questions online or on the Go365 App. Reach Bronze Status within 90 days of your Go365 program start or renewal date to remain eligible for program savings. Contact your HR department, or refer to your Plan Summary or Explanation of Benefits to determine program start date. If your savings appear inaccurate, sign in to your Go365.com account and visit the Communication Center to send us a secure message. Sending us a secure message is the best way to reach us while protecting your privacy.

Humana Inc. and its subsidiaries ("Humana") do not discriminate on the basis of race, color, national origin, age, disability or sex.

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-281-6918 (TTY: 711).**

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-281-6918 (TTY: 711).**

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-281-6918 (TTY: 711).**

GCHJM4REN 0816

Humana Vision 130

FLORIDA

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	Up to $130 20% off balance over $130	Up to $65
Standard plastic lenses[4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered lens options[4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- Tier 1	$57	Not covered
- Tier 2	$68	Not covered
- Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90, 80% of charge, then up to $120	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	Up to $130, 15% off balance over $130	Up to $104
• Disposable	Up to $130	Up to $104
• Medically necessary	$0	Up to $200

Humana Vision 130

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

Optional benefits

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis[1].

[1] Thompson Media Inc.

Questions

Check out Humana.com

Call 1-866-995-9316 seven days a week: 8 a.m. to 6 p.m. Eastern Time Monday through Saturday, and 11 a.m. to 8 p.m. Sunday.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana®

Choosing Humana Vision is good for your health

Besides checking for changes in your vision, your eye doctor can check for common eye conditions like glaucoma.

An eye exam can also uncover other health issues, such as high blood pressure and diabetes. If you have diabetes, most Humana Vision plans have additional coverage for the care and testing you need to help manage your condition.

Humana Vision makes good eye health easy and budget friendly

- Get an annual eye exam for $10
- Choose from more than 70,000 eye doctors in more than 24,000 locations including LensCrafters®, Pearle Vision®, Target Optical, Sears Optical®, JCPenney Optical and many other private practioners

Find an eye professional near You

Private Practitioners

Target Optical

Pearle Vision

LensCrafters

Online Retailers New to Humana Network

Glasses.com / Contactsdirect.com

To find an in-network provider, search at Humana.com

Humana®

Humana.com

GLASSES.COM

In-network now means online

We're changing the way benefits work - because online purchases of prescription glasses is projected to increase by 15% over the next 10 years.[1] And now that Glasses.com is in our network, You can go online to buy glasses anytime, from anywhere. And the best part is that You can use their in-network benefits.

It's easy:

- You can find a pair you love from thousands of name-brand frames
- Snap and send a picture of the prescription – or have Glasses.com call the provider for it
- Lenses available for most prescriptions (including progressives and multifocals)
- Orders fulfilled and shipped the following day – and it's free!
- All supported by the award winning[2] photorealistic and geometrically accurate 3D virtual "try-on" app for iPad and iPhone

Try glasses on at home

Risk Free

We'll send you frames you like in your prescription

You can wear them for 15 days

You can keep them or send them back - all with free shipping

You have a realistic way to try on glasses digitally:

Find frames
Thousands of styles rendered instantly in 3D

See from any angle
See how frames look from side to side

Share on Social Media
Get the opinions of family friends

See how our vision is changing reality

Download the app or visit Glasses.com today

[1]Estin & Co, 2013 estimates and analysis; Essilor International
[2]2014 Cannes Lions Festival, Bronze Award for "Creative Use of Technology"

Humana

CONTACTSDIRECT

You can now use their contact lens allowance online

We know that even though you are busy, you always have a mobile device ready or a computer nearby. That's why you can order contact lenses online using ContactsDirect when you need to - without leaving you home. And the best part is that you can use your in-network benefits to make sure you are getting the best price around.

Plus, you can be sure that you can find what you need because ContactsDirect stocks the best-selling brands. The site also offers a best-in-class user experience that allows you to view your eligibility and available allowance (with application directly in your shopping cart). All with fast, free shipping!

And don't worry, if you still prefer to visit their eye doctor in person to purchase contacts lenses, nothing has changed. ContactsDirect is just one more way we're helping you see life to the fullest.

Check out this new, online in-network benefit. Visit us at www.contactsdirect.com

It's an easy ordering process:

1

You will go to contactsdirect.com

2

You'll select your lenses from a wide selection of top selling brands

3

In-network vision benefits instantly apply to your purchase price

4

Contact lenses will ship as soon as the prescription is verified– most even ship that same day

*ContactsDirect will abide by state laws that pertain to contact lens.

**EyeMed internal research study, 2014

*** Members whose prescriptions are more than a year old will need an updated prescription to make an online or in-person purchase using their benefits.

Humana

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 identity, or religion. 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 **1-877-320-1235** 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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you.
1-877-320-1235 (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.

Language assistance services, free of charge, are available to you.
1-877-320-1235 (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