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, call 1-800-435-5694 or visit us at www.pbaclaims.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-435-5694 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	The calendar year deductible is: **$1,000** Individual / **$3,000** Family Prescription drug copayments don't apply to the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the 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, the following services are covered before you meet your deductible: preventive care, diabetic supplies purchased from Direct Healthcare, prescription drugs, hearing aids, and vision.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes, there is a separate calendar year deductible for dental care: **$50** Individual / **$150** Family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	The calendar year out-of-pocket limit is met after your coinsurance is applied to: **$15,000** of Eligible Expenses per Individual **$45,000** of Eligible Expenses per 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Deductibles, copayments, coinsurance for hearing aids, routine colorectal cancer screenings, and benefits payable at 50% if case management participation is declined, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	Maximum Benefit: Chiropractor: $1,000 per calendar year Naprapathy: $1,000 per calendar year
	Specialist visit	15% coinsurance	
	Preventive care/screening/ immunization	No charge (no deductible) for gynecological exam and pap smear/HPV test, prostate exam and PSA test and mammograms. 50% coinsurance (no deductible) for colonoscopy and fecal occult blood test.	Limits: 1 annual gynecological exam and pap; 1 annual HPV lab; 1 annual prostate exam and PSA; 1 mammogram between ages 35-39; 1 mammogram every 2 years ages 40-49; 1 annual mammogram age 50+; 1 colonoscopy every 24 months; 1 fecal occult blood test per year. No other routine exams are covered.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	15% coinsurance	————none————
If you need drugs to treat your illness or condition	Generic drugs	Not Applicable	Retiree drug coverage is provided separate from this Plan. More information is available from Humana Group Medicare Customer Care at www.humana.com or by calling (866) 396-8810.
	Preferred brand drugs	Not Applicable	
	Non-preferred brand drugs	Not Applicable	
	Specialty drugs	Not Applicable	
If you have outpatient surgery	Facility fee (ambulatory surgery center)	15% coinsurance	————none————
	Physician/surgeon fees	15% coinsurance	————none————
If you need immediate medical attention	Emergency room care	15% coinsurance	————none————
	Emergency medical transportation	15% coinsurance	————none————
	Urgent care	15% coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	————none————
	Physician/surgeon fees	15% coinsurance	————none————

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	————none————
	Inpatient services	10% coinsurance	————none————
If you are pregnant	Office visits	15% coinsurance	————none————
	Childbirth/delivery professional services	15% coinsurance	————none————
	Childbirth/delivery facility services (inpatient)	10% coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	15% coinsurance	————none————
	Rehabilitation services	15% coinsurance	————none————
	Habilitation services	15% coinsurance	————none————
	Skilled nursing care	15% coinsurance	————none————
	Durable medical equipment	15% coinsurance	Your cost for diabetic supplies purchased from Direct Healthcare: $20 copay (no deductible) / test strips 20% coinsurance (no deductible) / insulin pump and supplies 20% coinsurance / contracted supplies
	Hospice services	10% coinsurance (inpatient) 15% coinsurance (outpatient)	Bereavemment counseling: $500 maximum benefit per family.
If you or your child need dental or eye care	Eye exam	No charge, no deductible; one per 12-month period	Maximum Benefit: $50 per exam
	Glasses	No charge, no deductible; one per 12-month period	Maximum Benefit: $125/contact lenses; $90/frames; $85/single vision lenses; $105/bifocals; $125/progressive lenses
	Dental check-up	No charge, no deductible; two per calendar year	Maximum Benefit: $1,500 calendar year

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (unless diagnosed BMI of 31 or greater, then $500 max benefit for one qualified program)

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

- Acupuncture (performed by a physician)
- Chiropractic care ($1,000 calendar year max)
- Dental care ($1,500 calendar year maximum)
- Hearing aids (50% coinsurance, up to maximum benefit of $2,500 every 3 years)
- Infertility treatment (Creighton Model)
- Private-duty nursing
- Routine eye care (see limits above)

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Professional Benefit Administrators, Inc., 900 Jorie Blvd. Suite 250; Oak Brook, IL 60523-3827 or 1-800-435-5694. 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.

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

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-435-5694.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**15%**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$30
Coinsurance	$1,460
What isn't covered	
Limits or exclusions	$65
The total Peg would pay is	**$2,555**

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

The plan's overall deductible	**$1,000**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**15%**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$1,610
Coinsurance	$20
What isn't covered	
Limits or exclusions	$180
The total Joe would pay is	**$2,810**

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

The plan's overall deductible	**$1,000**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**15%**

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$5
Coinsurance	$270
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,275**

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