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 toll-free 1 (800) 822-5899. 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 1-800-822-5899 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$203 / individual for Medicare Part B	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?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. $25/individual (prescription drugs); $20/individual dental (waived for preventive and diagnostic care). There are no other specific deductibles.	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?	For prescription drugs $1,500/individual	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	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	No Charge	Medicare approved amounts.
	Specialist visit	No Charge	Medicare approved amounts. Acupuncture, infertility treatments and weight loss programs are not covered
	Preventive care/screening/ immunization	Not Covered	These services are excluded.
If you have a test	Diagnostic test (x-ray, blood work)	Blood tests - No Charge Other – No Charge	Medicare approved amounts. Tests are covered by Medicare in full.
	Imaging (CT/PET scans, MRIs)	No Charge	Medicare approved amounts.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Humana.com and by calling Labor First at (561) 264-0690 or (855) 893-0560.	Generic drugs	Retail (30) - 20% coinsurance, $5 minimum/prescription Retail (90) – 20% coinsurance, $15 minimum/prescription Mail - $10 copay/prescription	Humana Medicare Employer™ PDP Plan Retail (30): Up to a 30-day supply Retail (90): Up to a 90-day supply Mail: Up to a 90-day supply Specialty: Up to a 30-day supply Must use pharmacy network Prescription drug calendar year deductible applies. You pay the lower of actual cost or the minimum copayment. Preauthorization required for certain prescription drugs. If you don't get preauthorization, benefits could be reduced where plan pays nothing. Certain prescriptions are not covered; others may have quantity limits. Step therapy applies for certain drugs. Over-the-counter medications are not covered.
	Preferred brand drugs	Retail (30) - 25% coinsurance, $20 minimum/prescription Retail (90) - 25% coinsurance, $60 minimum/prescription Mail - $40 copay/prescription	
	Non-preferred brand drugs	Retail (30) - 25% coinsurance, $30 minimum/prescription Retail (90) - 25% coinsurance, $90 minimum/prescription Mail - $60 copay/prescription	
	Specialty drugs	Retail (30) - 25% coinsurance, $30 minimum/prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Medicare approved amounts.

*For more information about limitations and exceptions, see the plan or policy document at www.nebainc.com/mybenefits by calling 1-800 822-5899.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information*
	Physician/surgeon fees	No Charge	
If you need immediate medical attention	Emergency room care	No Charge	Medicare approved amounts.
	Emergency medical transportation	No Charge	Coverage maximum per illness or injury – Ground ambulance $1,200, Air ambulance $6,000. Special fee schedule used. Medicare approved amounts.
	Urgent care	No Charge	Medicare approved amounts.
If you have a hospital stay	Facility fee (e.g., hospital room)	100% coinsurance for the rest of the benefit period after 365 days once lifetime reserve days are used up	Medicare approved amounts. Bariatric surgery is excluded.
	Physician/surgeon fees	No Charge	Medicare approved amounts. Bariatric surgery is excluded.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health and behavioral health services - No Charge Substance abuse services - Not Covered	Medicare approved amounts. Coverage is excluded for substance abuse services.
	Inpatient services	Mental health and behavioral health services – No Charge. Substance abuse services - Not Covered.	Medicare approved amounts. Coverage is excluded for substance abuse services.
If you are pregnant	Office visits	No Charge	Medicare approved amounts.
	Childbirth/delivery professional services		
	Childbirth/delivery facility services	100% coinsurance for the rest of the benefit period after 365 days once lifetime reserve days are used up	Medicare approved amounts.
If you need help recovering or have other special health needs	Home health care	No Charge	Medicare approved amounts for Home health care services are covered by Medicare in full.
	Rehabilitation services	No Charge	Medicare approved amounts. Chiropractic coverage is limited to 15 visits per calendar year.
	Habilitation services	Not Covered	These services are excluded.
	Skilled nursing care	Not Covered	These services are excluded.
	Durable medical equipment	No Charge	Medicare approved amounts.

*For more information about limitations and exceptions, see the plan or policy document at www.nebainc.com/mybenefits by calling 1-800 822-5899.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information*
	Hospice services	No Charge	Medicare approved amounts for Hospice services are covered by Medicare in full.
If your child needs dental or eye care	Children's eye exam	$10 copay/exam	Coverage limited to one exam/year. Preauthorization is required for services. out-of-network providers - Fee schedule used
	Children's glasses	$15 copay/lenses and/or frames Vision Plan pays up to $100 for standard frames	Coverage limited to one pair of lenses/calendar year and one frame per two calendar years Preauthorization is required for services. out-of-network providers - Fee schedule used
	Children's dental check-up	20% coinsurance (deductible waived)	Coverage limited to two exams, two cleanings, one fluoride application and one bitewing x-ray per calendar year and one full mouth x-ray per two calendar years.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Certain prescription drugs are not covered
- Cosmetic surgery
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Over-the-counter medications
- Preventive care
- Routine foot care
- Skilled nursing facility services
- Substance abuse treatment
- Weight loss programs

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

- Chiropractic care
- Dental care (Adult)
- Private-duty nursing (limited to $2,000 per calendar year)
- Routine eye care (Adult)

*For more information about limitations and exceptions, see the plan or policy document at www.nebainc.com/mybenefits by calling 1-800 822-5899.

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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Plan at 1-800-822-5899 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) https://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 1-800-822-5899.]

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

*For more information about limitations and exceptions, see the plan or policy document at www.nebainc.com/mybenefits by calling 1-800 822-5899.

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	$203
Specialist coinsurance	0%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$214
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$314**

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

The plan's overall deductible	$203
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other (Rx) coinsurance	20%/25%

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*	$228
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,228**

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

The plan's overall deductible	$203
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$208
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$208**

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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