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 1-800-448-6262 or go to hr2.chevron.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.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 1-888-825-5247 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $**300** individual**/$600** 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, preventive services, diagnostic lab, lenses and frames following cataract surgery, hospital and physician services for a newborn, diabetic counseling, 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. 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:**$2,500** individual**/$5,000** family edical **,350**/ nd **12, 00** fam	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 does not cover and penalties for failure to obtain pre-authorization for services	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.	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). See www.humana.com to find HMO Premier participating providers.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment	Not covered	None
	Specialist visit	$40 copayment	Not covered	None
	Preventive care/screening/ immunization	No charge	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. Limitations on immunizations are according to the CDC guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Precertification is required; failure to do so can result in denial of benefits.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.humana.com.	Generic drugs (Level 1)	Retail: $10 copayment (30-day supply); Mail order: $25 copayment (90-day supply)	Not covered	Plan requires use of generic drugs when available. Prior authorization and/or step therapy is required for some medicines. Maintenance medicines must be filled by Humana's Mail Order Pharmacy to prevent penalty of two times copayment.
	Preferred brand drugs (Level 2)	Retail: $30 copayment (30-day supply); Mail order: $75 copayment (90-day supply)	Not covered	Plan requires use of generic drugs when available. Prior authorization and/or step therapy is required for some medicines. Maintenance medicines must be filled by Humana's Mail Order Pharmacy to prevent penalty of two times copayment.
	Non-preferred brand drugs (Level 3)	Retail:$50 copayment (30-day supply); Mail order: $125 copayment (90-day supply)	Not covered	Plan requires use of generic drugs when available. Prior authorization and/or step therapy is required for some medicines. Maintenance medicines must be filled by Humana's Mail Order Pharmacy to prevent

* For more information about limitations and exceptions, see the plan or policy document at www.MyHumana.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				penalty of two times copayment.
	Specialty drugs	Self-administered: applicable copayment applies, depending on level of drug. Office administered specialty drugs, dispensed through Humana Specialty Pharmacy: $0 copayment	Not covered	Prior authorization and/or step therapy is required for some medicines. Office administered specialty drugs not dispensed through Humana Specialty Pharmacy will be subject to applicable copayment.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Precertification is required; failure to do so can result in denial of benefits.
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$100 copayment	$100 copayment	Must be a true medical emergency to be covered.
	Emergency medical transportation	10% coinsurance	10% coinsurance after network deductible	None
	Urgent care	$40 copayment	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Precertification is required; failure to do so can result in denial of benefits.
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay	Not covered	None
	Inpatient services	10% coinsurance	Not covered	Precertification is required; failure to do so can result in denial of benefits.
If you are pregnant	Office visits	No charge	Not covered	Once pregnancy is confirmed, routine and post natal office visits are covered at 100%. You pay 10% coinsurance after the deductible for delivery.
	Childbirth/delivery professional services	10% coinsurance	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.MyHumana.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	Not covered	Precertification is suggested, but not required.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Precertification is required; failure to do so can result in denial of benefits. Limited to 100 (3 visits per day) visits.
	Rehabilitation services	$30 copayment	Not covered	Precertification is required; failure to do so can result in denial of benefits. Limited to 20 combined visits for physical, occupational and cognitive therapies. Speech therapy has unlimited visits.
	Habilitation services	$30 copayment	Not covered	Precertification is required; failure to do so can result in denial of benefits. Unlimited visits for physical, occupational, cognitive therapies and speech therapy.
	Skilled nursing care	10% coinsurance	Not covered	Precertification is required; failure to do so can result in denial of benefits. Limited to 100 days.
	Durable medical equipment	10% coinsurance	Not covered	Precertification may be required. Monthly rental is allowed, but not to exceed the purchase price of DME.
	Hospice services	10% coinsurance	Not covered	Precertification is required; failure to do so can result in denial of benefits. Limited to 180 days.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	No coverage for eye exams.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups.

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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care while traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight-loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.MyHumana.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (limited to 20 visits per year)	• Hearing aids (ages 17 and younger, 80% coverage for non-disposable aids limited to $1,400 per hearing aid every 36 months)	• Infertility treatment • Routine eye care (exam)

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. 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 Humana at 1-800-448-6262 or 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Language Access Services: See the attached Addendum.

———————————*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.MyHumana.com.

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	$300
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$1,172
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,592

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$7,390

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,005
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,114
The total Joe would pay is	$3,119

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$1,888

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$325
Coinsurance	$113
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$738

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

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- 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.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235 or send an email to accessibility@humana.com, or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-887-320-1235 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-887-320-1235 (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 **1-887-320-1235（TTY: 711）**。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-887-320-1235 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-887-320-1235 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-887-320-1235 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-887-320-1235 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-887-320-1235 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-887-320-1235 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-887-320-1235 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-887-320-1235 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-887-320-1235 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-887-320-1235 (TTY: 711)**.

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 **1-887-320-1235（TTY：711）**まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-887-320-1235 (TTY: 711)** تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-887-320-1235 (TTY: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-887-320-1235 (رقم هاتف الصم والبكم: 711)**.