Humana Simplicity NPOS 16

For groups 101+
Effective dates starting 8/1/19

Arizona Humana Simplicity

	If you use in-network providers		If you use out-of-network providers	
Annual deductible • The annual deductible is based upon a calendar or plan year • In-network and out-of-network deductibles accumulate separately	**Individual** N/A	**Family** N/A	**Individual** $5,000	**Family** $10,000
Maximum out-of-pocket limit • The maximum out-of-pocket limit is calculated on a calendar or plan year • Includes medical and pharmacy deductibles, copays and/or coinsurance	**Individual** **Option 1:** $3,500 **Option 2:** $4,000 **Option 3:** $5,000 **Option 4:** $6,000 **Option 5:** $6,500 **Option 6:** $6,500 **Option 7:** $7,900	**Family** $7,000 $8,000 $10,000 $12,000 $13,000 $13,000 $15,800	**Individual** **Option 1:** $10,500 **Option 2:** $12,000 **Option 3:** $15,000 **Option 4:** $18,000 **Option 5:** $19,500 **Option 6:** $19,500 **Option 7:** $23,700	**Family** $21,000 $24,000 $30,000 $36,000 $39,000 $39,000 $47,400
Physician services				
• Office visits	100% after **Option 1:** $20 primary care/$35 specialist **Option 2:** $25 primary care/$40 specialist **Option 3:** $25 primary care/$55 specialist **Option 4:** $25 primary care/$65 specialist **Option 5:** $30 primary care/$75 specialist **Option 6:** $30 primary care/$100 specialist **Option 7:** $40 primary care/$80 specialist		50% after deductible	
• Retail clinic visits	100% after primary care copay		50% after deductible	
• Urgent care visits	**Option 1:** 100% after $75 copay **Option 2:** 100% after $75 copay **Option 3:** 100% after $100 copay **Option 4:** 100% after $100 copay **Option 5:** 100% after $125 copay **Option 6:** 100% after $125 copay **Option 7:** 100% after $125 copay		50% after deductible	

	If you use in-network providers	If you use out-of-network providers
Facility services		
• Inpatient services	**Option 1:** 100% after $250 copay for one day per admission **Option 2:** 100% after $500 copay for one day per admission **Option 3:** 100% after $500 copay for first three days per admission **Option 4:** 100% after $700 copay for first three days per admission **Option 5:** 100% after $1,000 copay for first three days per admission **Option 6:** 100% after $1,500 copay for first three days per admission **Option 7:** 100% after $2,000 copay for first three days per admission	50% after deductible
• Outpatient and ambulatory surgery	**Option 1:** 100% after $250 copay per visit **Option 2:** 100% after $500 copay per visit **Option 3:** 100% after $500 copay per visit **Option 4:** 100% after $700 copay per visit **Option 5:** 100% after $1,000 copay per visit **Option 6:** 100% after $1,500 copay per visit **Option 7:** 100% after $2,000 copay per visit	50% after deductible
• Urgent care	100%	50% after deductible
• Emergency room	**Option 1:** 100% after $150 copay per visit **Option 2:** 100% after $250 copay per visit **Option 3:** 100% after $350 copay per visit **Option 4:** 100% after $375 copay per visit **Option 5:** 100% after $500 copay per visit **Option 6:** 100% after $600 copay per visit **Option 7:** 100% after $600 copay per visit	**Option 1:** 100% after $150 copay per visit **Option 2:** 100% after $250 copay per visit **Option 3:** 100% after $350 copay per visit **Option 4:** 100% after $375 copay per visit **Option 5:** 100% after $500 copay per visit **Option 6:** 100% after $600 copay per visit **Option 7:** 100% after $600 copay per visit

Preauthorization: Humana requires preauthorization for some services and procedures. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at Humana.com or call Customer Service. Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits.

Providers: Primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by covered persons.

Additional Coverage Information: Please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate coverage. This guide is available at https://www.humana.com/insurance-through-employer/enrollment-center/pre-enrollment-disclosure or through your sales representative.

MEDICAL LIMITATIONS AND EXCLUSIONS

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing the procedure, treatment or supply. However, the procedure, treatment or supply will not be a covered expense.

Unless specifically states otherwise, no benefits will be provided for, or on account of, the following items:

- Treatments, services, supplies or surgeries that are not medically necessary, except for the preventive services.
- A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit if the person is insured, or is required to be insured by Workers' Compensation.
- Care and treatment given in a hospital owned, or run, by any government entity, unless you are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to Covered Persons who are armed services retirees and their dependents are not excluded.
- Any service furnished while you are confined in a hospital or institution owned or operated by the United States government or any of its agencies for any military service-connected sickness or bodily injury.
- Services, or any portion of a service, for which no charge is made.
- Services or any portion of a service, you would not be required to pay for, or would not have been charged for, in the absence of this insurance.
- Any portion of the amount we determine you owe for a service that the provider waives, rebates or discounts, including your copayment, deductible or coinsurance.
- Sickness or bodily injury for which you are in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid.
- Any service not ordered by a health care practitioner.
- For HMO Plans: Services provided to you, if you do not comply with the master group contract's requirements. These include services:
  - Not provided by a network provider, unless required for emergency care or as otherwise specified in the certificate;
  - Received in an emergency room, unless required because of emergency care;
  - Which require preauthorization if preauthorization was not obtained;
  - Which require a primary care physician referral if a referral was not obtained; and
  - Which require a primary care physician referral if a referral was not obtained.
- Services rendered by a standby physician, surgical assistant or assistant surgeon, unless medically necessary.
- Any service that is not rendered by the billing provider.
- Any service not substantiated in the medical records of the billing provider.
- Any amount billed for a professional component of an automated:
  - Laboratory service; or
  - Pathology service.
- For PPO plans: Expenses for services, prescriptions, equipment or supplies received outside the United States or from a foreign provider, unless:
  For emergency care;
  - The employee is traveling outside the United States due to employment with the employer sponsoring the policy and the services are not covered under any Workers' Compensation or similar law; or

- The employee and dependents live outside the United States and the employee is in active status with the employer sponsoring the policy.

- Education or training, except for diabetes self-management training and habilitative services.
- Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books, and similar materials are also excluded.
- For PPO plans: Services provided by a covered person's family member.
- Ambulance services for routine transportation to, from or between medical facilities and/or a health care practitioner's office.
- For PPO plans: Any drug, biological product, device, medical treatment, or procedure which is experimental, investigational or for research purposes.
- For HMO/NPOS plans: Any drug, biological product, device, medical treatment, or procedure which is experimental, investigational or for research purposes, except for clinical trials as described in the "Covered Expenses" section of the certificate
- Prescription drugs and self-administered injectable drugs, except as specified in the "Covered Expenses – Pharmacy Services" section in this certificate or unless administered to you:

  - While an inpatient in a hospital, skilled nursing facility, health care treatment facility or residential treatment facility;
  - By the following, when deemed appropriate by us:

    - A health care practitioner:

      - During an office visit; or
      - While an outpatient; or

    - A home health care agency as part of a covered home health care plan.

- Vitamins, except for preventive services with a prescription from a health care practitioner, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disorder, e.g. phenylketonuria (PKU).
- Over-the-counter, non-prescription medications, unless for drugs, medicines or medications or supplies on the Preventive Medication Coverage drug list, with a prescription from a health care practitioner.
- Over-the-counter medical items or supplies that can be provided or prescribed by a health care practitioner but are also available without a written order or prescription, except for preventive services.
- Growth hormones, except as otherwise specified in the pharmacy services sections of this certificate.
- For PPO / Indemnity plans: Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in this certificate.
- Prescription drugs and self-administered injectable drugs, except as specified in the "Covered Expenses – Pharmacy Services" section in this certificate or unless administered to you:

  - While an inpatient in a hospital, skilled nursing facility, health care treatment facility or residential treatment facility;
  - By the following, when deemed appropriate by us:

    - A health care practitioner:

      - During an office visit; or
      - While an outpatient; or

    - A home health care agency as part of a covered home health care plan.

- Services received in an emergency room, unless required because of emergency care.
- Weekend non-emergency hospital admissions, specifically admissions to a hospital on a Friday or Saturday at the convenience of the Covered Person or his or her health care practitioner when there is no cause for an emergency admission and the Covered Person receives no surgery or therapeutic treatment until the following Monday.
- Hospital inpatient services when you are in observation status.
- Infertility services; or reversal of elective sterilization.
- In vitro fertilization, regardless of the reason for treatment.
- Services for or in connection with a transplant or immune effector cell therapy if:
    - The expense relates to storage of cord blood and stem cells, unless it is an integral part of a transplant approved by us.
    - Not approved by us, based on our established criteria.
    - Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
    - The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the policy.
    - The expense relates to the donation or acquisition of an organ for a recipient who is not covered by us.
    - The expense relates to donor costs that are payable in whole or in part by any other group plan, insurance company, organization, or person other than the donor's family or estate.
    - The expense relates to a transplant or immune effector cell therapy performed outside of the United States and any care resulting from that transplant or immune effector cell therapy. This exclusion applies, even if the employee and dependents live outside the United States and the employee is in active status with the employer sponsoring the policy.
- Services provided for:
    - Immunotherapy for recurrent abortion;
    - Chemonucleolysis;
    - Sleep therapy;
    - Light treatments for Seasonal Affective Disorder (S.A.D.);
    - Immunotherapy for food allergy;
    - Prolotherapy; or
    - Sensory integration therapy.
- Cosmetic surgery and cosmetic services or devices.
- Hair prosthesis, hair transplants or implants, and wigs.
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery, endodontic services or periodontics, implants and related procedures, orthodontic procedures, and any dental services related to a bodily injury or sickness unless otherwise stated in the certificate.
- The following types of care of the feet:
    - Shock wave therapy of the feet;
    - The treatment of weak, strained, flat, unstable or unbalanced feet;
    - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratoses;
    - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
    - The cutting of toenails, except the removal of the nail matrix;
    - Heel wedges, lifts, or shoe inserts; and
    - Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammertoe.
- Custodial care and maintenance care.
- Any loss contributed to, or caused by:
    - War or any act of war, whether declared or not;

- Insurrection; or
- Any conflict involving armed forces of any authority.

- Expenses for any membership fees or program fees paid by you, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or surgical programs, and any materials or products related to these programs.
- Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss surgery.
- Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a health care practitioner) and certain medical devices including, but not limited to:
  - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
  - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
  - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
  - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
  - Medical equipment including:
    - Blood pressure monitoring devices, unless prescribed by a health care practitioner for preventive services and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension;
    - PUVA lights; and
    - Stethoscopes;
  - Communication systems, telephone, television or computer systems and related equipment or similar items or equipment;
  - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

- Duplicate or similar rentals or purchases of durable medical equipment or diabetes equipment.

- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
  - The American Academy of Allergy and Immunology; or
  - The Department of Health and Human Services or any of its offices or agencies.

- Lodging accommodations or transportation, except as indicated under transplant and immune effector cell therapy services within the certificate:
  - For HMO/NPOS plans: And coverage of travel expenses to receive approved services from a non-network provider.
- Communications or travel time.
- Bariatric surgery, any services or complications related to bariatric surgery, and other weight loss products or services.
- Sickness or bodily injury for which no-fault medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.
- Elective medical or surgical abortion unless:
  - The pregnancy would endanger the life of the mother; or
  - The pregnancy is a result of rape or incest; or

- Alternative medicine.
- Acupuncture, unless:
  - The treatment is medically necessary, appropriate and is provided within the scope of the acupuncturist's license; and
  - You are directed to the acupuncturist for treatment by a licensed physician.
- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
- Services of a midwife, unless the midwife is licensed.
- Vision examinations or testing for the purposes of prescribing corrective lenses.
- Orthoptic/vision training (eye exercises).
- Radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error.
- The purchase or fitting of eyeglasses or contact lenses, except as the result of an accident or following cataract surgery as stated in the contract.
- Services and supplies which are:
  - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or
  - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.
- Marriage counseling.
- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the effective date or after the termination date of your coverage under the policy or master group contract. Coverage will be extended as described in the "Extension of Benefits" section of the certificate, as required by state law.
- For HMO plans: Any care, treatment, services, equipment or supplies received outside of the service area:
  - If you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
  - Which are not authorized by us.
- For HMO plans: Any expense incurred for services received outside of the United States except for emergency care, as required by law and specified in the "Covered Expenses" section, or services authorized by us to be provided by a non-network provider.
- Expenses incurred by you for the treatment of any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull, except as a result of an accident, trauma, a congenital anomaly, a developmental defect or a pathology.
- Pre-surgical/procedural testing duplicated during a hospital confinement.

COVERED EXPENSE LIMITATIONS AND EXCLUSIONS

- Home health care covered expenses do not include:
  - Charges for mileage or travel time to and from the covered person's home;
  - Wage or shift differentials for any representative of a home health care agency;

- Charges for supervision of home health care agencies;
- Charges for services of a home health aide;
- Custodial care; or
- The provision or administration of self-administered injectable drugs, unless otherwise determined by us.

- Hospice care covered expenses do not include:

  - A confinement not required for acute pain control or other treatment for an acute phase of chronic symptom management;
  - Services by volunteers or persons who do not regularly charge for their services;
  - Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
  - Bereavement counseling services for family members not covered under the policy.

- Orthotic Covered expenses do not include:

  - Replacement orthotics;
  - Dental braces; or
  - Oral or dental splints and appliances, unless custom made for the treatment of documented obstructive sleep apnea.

- Routine costs in a clinical trial do not include services or items that are:

  - Experimental, investigational or for research purposes;
  - Provided only for data collection and analysis that is not directly related to the clinical management of the covered person; or
  - Inconsistent with widely accepted and established standards of care for a diagnosis.

- Covered expense for prosthetic devices includes repair or replacement, if covered by the manufacturer.

- Repair and maintenance of purchased durable medical equipment and diabetes equipment unless:

  - Manufacturer's warranty is expired; and
  - Repair or maintenance is not a result of misuse or abuse; and
  - Repair cost is less than replacement cost.

- Replacement of purchased durable medical equipment and diabetes equipment unless:

  - Manufacturer's warranty is expired; and
  - Replacement cost is less than repair cost; and
  - Replacement is not due to lost or stolen equipment, or misuse or abuse of the equipment; or
  - Replacement is required due to a change in your condition that makes the current equipment non-functional.

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:

- Legend drugs, which are not deemed medically necessary by us.
- Prescription drugs not included on the drug list.
- Any amount exceeding the default rate.
- Specialty drugs for which coverage is not approved by us.
- Drugs not approved by the FDA.

- Any drug prescribed for intended use other than for:
  - Indications approved by the FDA; or
  - Off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a sickness or bodily injury not covered under the policy / master group contract.
- Any drug, medicine or medication that is either:
  - Labeled "Caution-limited by federal law to investigational use;" or
  - Experimental, or investigational or for research purposes, even though a charge is made to you.
- Allergen extracts.
- Therapeutic devices or appliances, including, but not limited to:
  - Hypodermic needles and syringes (except when prescribed by a health care practitioner for use with insulin and self-administered injectable drugs, whose coverage is approved by us);
  - Support garments;
  - Test reagents;
  - Mechanical pumps for delivery of medications; and
  - Other non-medical substances.
- Dietary supplements and nutritional products, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or other inherited metabolic disease or eosinophilic gastrointestinal disorders.
- For PPO and HMO / NPOS Plans: Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage drug list when obtained from a network pharmacy with a prescription from a health care practitioner.
- For Indemnity Plans: Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage drug list when obtained from a pharmacy with a prescription from a health care practitioner.
- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by us.
- For Indemnity Plans: Non-prescription, over-the-counter minerals, except as specified on the Preventive Medication Coverage drug list when obtained from a pharmacy with a prescription from a health care practitioner.
- Growth hormones for idiopathic short stature or any other condition, unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by us.
- For PPO and HMO / NPOS Plans: Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage drug list when obtained from a network pharmacy with a prescription from a health care practitioner.
- For Indemnity Plans: Herbs and vitamins, except prenatal (including greater than one milligram of folic acid), pediatric multi-vitamins with fluoride and vitamins on the Preventive Medication Coverage drug list when obtained from a pharmacy with a prescription from a health care practitioner.
- Anabolic steroids.
- Any drug used for the purpose of weight loss.
- Any drug used for cosmetic purposes, including but not limited to:
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents.
- Any drug or medicine that is lawfully obtainable without a prescription (over-the-counter drugs), except:

- Insulin; and
- For PPO and HMO / NPOS Plans: Drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list when obtained from a network pharmacy with a prescription from a health care practitioner.
- For Indemnity Plans: Drugs, medicines or medications and supplies on the Preventive Medication Coverage drug list when obtained from a pharmacy with a prescription from a health care practitioner.

- Compounded drugs that:
  - Are prescribed for a use or route of administration that is not FDA approved or compendia supported;
  - Are prescribed without a documented medical need for specialized dosing or administration;
  - Only contain ingredients that are available over-the-counter;
  - Only contain non-commercially available ingredients; or
  - Contain ingredients that are not FDA approved, including bulk compounding powders.
- Abortifacients (drugs used to induce abortions).
- Infertility services including medications.
- Any drug prescribed for impotence and/or sexual dysfunction.
- Any drug, medicine or medication that is consumed or injected at the place where the prescription is given, or dispensed by the health care practitioner.
- The administration of covered medication(s).
- Prescriptions that are to be taken by or administered to you, in whole or in part, while you are a patient in a facility where drugs are ordinarily provided on an inpatient basis by the facility. Inpatient facilities include, but are not limited to:
  - Hospital;
  - Skilled nursing facility; or
  - Hospice facility.
- Injectable drugs, including, but not limited to:
  - Immunizing agents, unless for preventive services determined by us to be dispensed by or administered in a pharmacy;
  - Biological sera;
  - Blood;
  - Blood plasma; or
  - Self-administered injectable drugs or specialty drugs for which prior authorization or step therapy is not obtained from us.
- Prescription fills or refills:
  - In excess of the number specified by the health care practitioner; or
  - Dispensed more than one year from the date of the original order.
- Any portion of a prescription fill or refill that exceeds a 90-day supply when received from a mail order pharmacy or a retail pharmacy that participates in our program, which allows you to receive a 90-day supply of a prescription fill or refill.
- Any portion of a prescription fill or refill that exceeds a 30-day supply when received from a retail pharmacy that does not participate in our program, which allows you to receive a 90-day supply of a prescription fill or refill.
- Any portion of a specialty drug prescription fill or refill that exceeds a 30-day supply, unless otherwise determined by us.
- Any portion of a prescription fill or refill that:
  - Exceeds our drug specific dispensing limit;
  - Is dispensed to a Covered Person, whose age is outside the drug specific age limits defined by us;

- Is refilled early, as defined by us; or
- Exceeds the duration-specific dispensing limit.

- Any drug for which we require prior authorization or step therapy and it is not obtained.
- Any drug for which a charge is customarily not made.
- Any drug, medicine or medication received by you:
  - Before becoming covered; or
  - After the date your coverage has ended.
- Any costs related to the mailing, sending or delivery of prescription drugs.
- Any intentional misuse of the prescription drug benefit, including prescriptions purchased for consumption by someone other than you.
- Any prescription fill or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged.
- Drug delivery implants and other implant systems or devices.
- Treatment for onychomycosis (nail fungus).
- For HMO plans: Any amount you paid for a prescription that has been filled, regardless of whether the prescription is revoked or changed due to adverse reaction or change in dosage or prescription.
- For HMO plans: Prescriptions filled at a non-network pharmacy, except for prescriptions required during an emergency.

Offered by Humana Health Plan, Inc. and insured by Humana Insurance Company

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.