

# Humana Simplicity NPOS 16

For groups 101+

Effective dates starting 1/1/22

## Ohio Humana Simplicity

	If you use in-network providers		If you use out-of-network providers	
<b>Annual deductible</b> <ul style="list-style-type: none"> <li>The annual deductible is based upon a calendar or plan year</li> <li>In-network and out-of-network deductibles accumulate separately</li> </ul>	Individual N/A	Family N/A	Individual \$5,000	Family \$10,000
<b>Maximum out-of-pocket limit</b> <ul style="list-style-type: none"> <li>The maximum out-of-pocket limit is calculated on a calendar or plan year</li> <li>Includes medical and pharmacy deductibles, copays and/or coinsurance</li> </ul>	<b>Individual</b> <b>Option 1:</b> \$3,500 <b>Option 2:</b> \$4,000 <b>Option 3:</b> \$5,000 <b>Option 4:</b> \$6,000 <b>Option 5:</b> \$6,500 <b>Option 6:</b> \$6,500 <b>Option 7:</b> \$7,900 <b>Option 25:</b> \$8,700	<b>Family</b> <b>Option 1:</b> \$7,000 <b>Option 2:</b> \$8,000 <b>Option 3:</b> \$10,000 <b>Option 4:</b> \$12,000 <b>Option 5:</b> \$13,000 <b>Option 6:</b> \$13,000 <b>Option 7:</b> \$15,800 <b>Option 25:</b> \$17,400	<b>Individual</b> <b>Option 1:</b> \$10,500 <b>Option 2:</b> \$12,000 <b>Option 3:</b> \$15,000 <b>Option 4:</b> \$18,000 <b>Option 5:</b> \$19,500 <b>Option 6:</b> \$19,500 <b>Option 7:</b> \$23,700 <b>Option 25:</b> \$26,100	<b>Family</b> <b>Option 1:</b> \$21,000 <b>Option 2:</b> \$24,000 <b>Option 3:</b> \$30,000 <b>Option 4:</b> \$36,000 <b>Option 5:</b> \$39,000 <b>Option 6:</b> \$39,000 <b>Option 7:</b> \$47,400 <b>Option 25:</b> \$52,200
<b>Physician services</b> <ul style="list-style-type: none"> <li>Office visits</li> <li>Retail clinic visits</li> <li>Urgent care visits</li> </ul>	100% after <b>Option 1:</b> \$20 primary care/\$35 specialist <b>Option 2:</b> \$25 primary care/\$40 specialist <b>Option 3:</b> \$25 primary care/\$55 specialist <b>Option 4:</b> \$25 primary care/\$65 specialist <b>Option 5:</b> \$30 primary care/\$75 specialist <b>Option 6:</b> \$30 primary care/\$100 specialist <b>Option 7:</b> \$40 primary care/\$80 specialist <b>Option 25:</b> \$50 primary care/\$90 specialist		50% after deductible  50% after deductible 50% after deductible	

**Facility services**

• Inpatient services	<b>Option 1:</b> 100% after \$250 copay for one day per admission <b>Option 2:</b> 100% after \$500 copay for one day per admission <b>Option 3:</b> 100% after \$500 copay for first three days per admission <b>Option 4:</b> 100% after \$700 copay for first three days per admission <b>Option 5:</b> 100% after \$1,000 copay for first three days per admission <b>Option 6:</b> 100% after \$1,500 copay for first three days per admission <b>Option 7:</b> 100% after \$2,000 copay for first three days per admission <b>Option 25:</b> 100% after \$2,500 copay for first three days per admission	50% after deductible
• Outpatient and ambulatory surgery	<b>Option 1:</b> 100% after \$250 copay per visit <b>Option 2:</b> 100% after \$500 copay per visit <b>Option 3:</b> 100% after \$500 copay per visit <b>Option 4:</b> 100% after \$700 copay per visit <b>Option 5:</b> 100% after \$1,000 copay per visit <b>Option 6:</b> 100% after \$1,500 copay per visit <b>Option 7:</b> 100% after \$2,000 copay per visit <b>Option 25:</b> 100% after \$2,500 copay per visit	50% after deductible
• Urgent care	100%	50% after deductible
• Emergency room	<b>Option 1:</b> 100% after \$150 copay per visit <b>Option 2:</b> 100% after \$250 copay per visit <b>Option 3:</b> 100% after \$350 copay per visit <b>Option 4:</b> 100% after \$375 copay per visit <b>Option 5:</b> 100% after \$500 copay per visit <b>Option 6:</b> 100% after \$600 copay per visit <b>Option 7:</b> 100% after \$600 copay per visit <b>Option 25:</b> 100% after \$600 copay per visit	<b>Option 1:</b> 100% after \$150 copay per visit <b>Option 2:</b> 100% after \$250 copay per visit <b>Option 3:</b> 100% after \$350 copay per visit <b>Option 4:</b> 100% after \$375 copay per visit <b>Option 5:</b> 100% after \$500 copay per visit <b>Option 6:</b> 100% after \$600 copay per visit <b>Option 7:</b> 100% after \$600 copay per visit <b>Option 25:</b> 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.

Offered by Humana Health Plan of Ohio, 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.

