

High-deductible health plan

Health savings account (HSA) compatible
Summary of Benefits

Jan. 1–Dec. 31, 2022
Plan year

Plan pays for services
at National POS-Open
Access Plus providers

Plan pays for services at
out-of-network providers

Annual deductible (amount paid by member per plan year)¹

Individual (applies to individual coverage only)	\$3,000	\$6,000
Family (applies to all other coverage levels)	\$6,000	\$12,000

Coinsurance (amount paid by the plan after deductible)

80%	60%
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Maximum out-of-pocket (MOOP) limits (amount paid by member, including deductible, copays and coinsurance per plan year for medical and pharmacy expenses combined)^{2,3}

Individual (applies to individual coverage only)	\$4,500	\$9,000
Family (applies to all other coverage levels)	\$9,000 ⁴	\$18,000

Lifetime maximum benefit

Unlimited	Unlimited
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Preventive services (Routine expenses are those not incurred as a result of a diagnosis of a specific bodily injury or sickness.)

Routine child care (to age 18)	100%	60% after deductible
Routine adult physical exam (18 years and above)	100%	60% after deductible
Routine immunizations	100%	60% after deductible
Routine Pap smear/mammogram	100%	60% after deductible
Routine lab test/X-rays associated with routine physical exam	100%	60% after deductible
Routine endoscopic services (including colonoscopy)	100%	60% after deductible
Oral contraceptives and contraceptive supplies and devices ⁵	100%	60% after deductible
Breastfeeding supplies and devices ⁶	100%	60% after deductible
Lung cancer screening	100%	60% after deductible

Physician services

Office visits	80% after deductible	60% after deductible
Allergy testing, injections and serum	80% after deductible	60% after deductible
Emergency room physician services (in-network benefits paid if medical emergency)	80% after deductible	60% after deductible
Inpatient	80% after deductible	60% after deductible
Outpatient surgery (including surgery performed in the physician's office)	80% after deductible	60% after deductible
Outpatient nonsurgical (including tests, lab/X-rays)	80% after deductible	60% after deductible



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Hospital services		
Inpatient care ⁷	80% after deductible	60% after deductible
Outpatient surgery – facility	80% after deductible	60% after deductible
Ambulatory surgical center – outpatient surgery	80% after deductible	60% after deductible
Outpatient endoscopic services	80% after deductible	60% after deductible
Outpatient nonsurgical (including tests, lab/X-rays)	80% after deductible	60% after deductible
Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) ⁷	80% after deductible	60% after deductible
Hospital emergency services (in-network benefits paid if medical emergency)	80% after deductible	60% after deductible
Urgent care center	80% after deductible	60% after deductible
Mental health/substance abuse services		
Inpatient services ⁷	80% after deductible	60% after deductible
Inpatient professional services ⁷	80% after deductible	60% after deductible
Outpatient therapy session	80% after deductible	60% after deductible
Outpatient services at a residential treatment facility	80% after deductible	60% after deductible
Additional medical services		
Physical (PT), speech (ST), occupational (OT), hearing, cognitive therapy (60 total visits per plan year for all modalities combined) ^{7,8}	80% after deductible	60% after deductible
Chiropractic (30 visits per plan year) ⁸	80% after deductible	60% after deductible
Home health care (100 visits per plan year) ^{7,8}	80% after deductible	60% after deductible
Durable medical equipment ⁷	80% after deductible	60% after deductible
Skilled nursing facility (60 days per plan year) ^{7,8}	80% after deductible	60% after deductible
Ambulance (in-network benefits paid if medical emergency)	80% after deductible	60% after deductible
Transplant services ^{7,9}	80% after deductible	60% after deductible
Fertility counseling and treatment (up to \$10,000 lifetime limit) ¹⁰	80% after deductible	60% after deductible
Morbid obesity treatment (including limited covered surgical procedures) (up to \$10,000 lifetime limit) ^{7,10}	80% after deductible	60% after deductible
Hearing aids (covered up to \$1,400 per ear every 3 plan years)	80% after deductible	60% after deductible
Acupuncture (up to 12 visits per plan year) ^{8,11}	80% after deductible	80% after in-network deductible
Nutrition/dietitian counseling for:		
• Diabetes and obesity	100%	60% after deductible
• Eating disorders, cancer, celiac disease, rheumatoid arthritis and inflammatory bowel disease	80% after deductible	60% after deductible

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Hospice services⁷

Inpatient/outpatient

80% after deductible

60% after deductible

Prescription drugs (amount paid by member)

Preventive Rx medicines¹²

No cost when filled at a
Humana-owned pharmacy
(when filled at any other
in-network pharmacy,
subject to Rx4 cost share)

30% after deductible plus any
amount over the default rate³

Tobacco-cessation medicines
(including over the counter medicines
when prescribed by a physician)

No cost

30% after deductible plus any
amount over the default rate³

Other medicines (Rx4)¹³

- Level 1

\$10 copay after deductible

30% after deductible plus any
amount over the default rate³

- Level 2

\$40 copay after deductible

30% after deductible plus any
amount over the default rate³

- Level 3

\$70 copay after deductible

30% after deductible plus any
amount over the default rate³

- Level 4

25% after deductible

30% after deductible plus any
amount over the default rate³



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Payments

Plan benefits are paid based on maximum allowable fees, as defined in your Summary Plan Description. In-network providers agree to accept maximum allowable fees, as listed in negotiated payment schedules, as payment in full.

For services rendered by out-of-network providers, the member is responsible for charges exceeding a maximum allowable fee selected by your employer. For services from other out-of-network providers as well as emergency, ambulance and/or urgent services received while out of the service area that are covered at in-network provider benefit levels, the member may be responsible for charges that exceed maximum allowable fees.

Humana's medical plans are self-insured, which means that certain state-mandated benefits may not be covered. To be covered, services must be medically necessary and specified as covered. Certain services require prior authorization.

Please see your Summary Plan Description for more information on medical necessity and other specific plan benefit limitations.

¹For coverage other than individual coverage, the family deductible applies; no individual deductible applies.

²For coverage other than individual coverage, the family maximum out of pocket (MOOP) applies; no individual MOOP applies.

³Coinsurance (member amount) for out-of-network pharmacies does not apply to the maximum out-of-pocket limits.

⁴Each person on a family plan will pay no more than \$8,700 for covered, in-network services. This amount includes both the deductible and coinsurance combined.

⁵Brand-name contraceptives are covered at 100% before deductible only when no generic alternative is available in that class or category.

⁶Breastfeeding supplies and devices must be purchased or rented from an in-network DME provider or qualified healthcare practitioner to be covered at 100% before deductible. Humana does not cover breast pumps or supplies purchased at a retail store.

⁷Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies payment under your benefit plan. You and your healthcare provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our website at [Humana.com/members/tools](https://www.humana.com/members/tools) or call Customer Care. Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your healthcare practitioner should call Customer Care to obtain preauthorization.

⁸Services received before or after the deductible is met will apply to the member's day/visit limit as specified by the given benefit.

⁹The National Transplant Network includes in-network providers for transplant services. All other providers will be considered out-of-network providers.

¹⁰In-network and out-of-network expenses combine to the maximum benefit of \$10,000 per covered person, per lifetime.

¹¹In-network and out-of-network visit limits combine to a maximum of 12 visits per covered person, per plan year.

¹²Preventive Rx includes generic and preferred brand-name medicines (without a generic equivalent) for diabetes and diabetic supplies, heart (blood pressure and cholesterol) and blood agents/thinners.

¹³Following the initial fill and one refill of a covered specialty medicine, the third and subsequent fills will not be covered if not obtained through Humana Specialty Pharmacy or a designated pharmacy. For more information, see your Summary Plan Description.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
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 their Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides 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.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wóda'í beésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك