Out-of-area, Virtual First health plan

Includes personal care account
Summary of Benefits

Jan. 1–Dec. 31, 2022 Plan year	**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
Family (applies to all other coverage levels)	$6,000
Coinsurance (amount paid by the plan after deductible)	
	80%
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
Family (applies to all other coverage levels)	$9,000[4]
Lifetime maximum benefit	
	Unlimited
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% after deductible
Routine adult physical exam (18 years and above)	100% after deductible
Routine immunizations	100% after deductible
Routine Pap smear/mammogram	100% after deductible
Routine lab test/X-rays associated with routine physical exam	100% after deductible
Routine endoscopic services (including colonoscopy)	100% after deductible
Oral contraceptives and contraceptive supplies and devices[5]	100% after deductible
Breastfeeding supplies and devices[6]	100% after deductible
Lung cancer screening	100% after deductible
Doctor on Demand (virtual visits excluding tests, labs/x-rays)	
Primary care physician	100%
Urgent care	100%
Behavioral health	100%

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Jan. 1–Dec. 31, 2022 Plan year	**Plan pays for services at out-of-network providers**
Physician services	
Office visits	
• Primary care physician	100% after $50 copay
• Specialist	100% after $100 copay
Allergy injections	100% after $5 copay per injection
Allergy testing and serum	80% after deductible
Emergency room physician services	80% after deductible
Inpatient	80% after deductible
Surgery performed in the physician's office	80% after deductible
Advanced imaging (PET, MRI, MRA, CAT, SPECT)[7]	80% after deductible
Office visits with primary diagnosis of diabetes	100%
Hemoglobin A1c lab test with primary diagnosis of diabetes	100%
Vision exams with primary diagnosis of diabetes	100%
Foot exams with primary diagnosis of diabetes	100%
Hospital services	
Inpatient care[7]	80% after deductible
Outpatient surgery – facility	80% after deductible
Ambulatory surgical center – outpatient surgery	80% after deductible
Outpatient endoscopic services	80% after deductible
Outpatient nonsurgical (including tests, lab/X-rays)	80% after deductible
Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)[7]	80% after deductible
Hospital emergency services (in-network benefits paid if medical emergency)	80% after deductible
Urgent care center	100% after $125 copay
Mental health/substance abuse services	
Inpatient services[7]	80% after deductible
Inpatient professional services[7]	80% after deductible
Outpatient therapy session	100% after $50 copay
Outpatient services at a residential treatment facility	100% after $50 copay
Additional medical services	
Physical (PT), speech (ST), occupational (OT), hearing, cognitive therapy (60 total visits per plan year for all modalities combined)[7,8]	100% after $100 copay
Chiropractic (30 visits per plan year)[8]	100% after $100 copay
Home health care (100 visits per plan year)[7,8]	80% after deductible
Durable medical equipment[7]	80% after deductible
Skilled nursing facility (60 days per plan year)[7,8]	80% after deductible
Ambulance (in-network benefits paid if medical emergency)	80% after deductible
Transplant services[7,9]	80% after deductible
Fertility counseling and treatment (up to $10,000 lifetime limit)[10]	80% after deductible

Jan. 1–Dec. 31, 2022 Plan year	**Plan pays for services at out-of-network providers**
Additional medical services continued	
Morbid obesity treatment (including limited covered surgical procedures) (up to $10,000 lifetime limit)[7,10]	80% after deductible
Hearing aids (covered up to $1,400 per ear every 3 plan years)	80% after deductible
Acupuncture (up to 12 visits per plan year)[8,11]	
Nutrition/dietitian counseling for: • Diabetes and obesity • Eating disorders, cancer, celiac disease, rheumatoid arthritis and inflammatory bowel disease	100% 100% after office visit copay
Hospice services[7]	
Inpatient/outpatient	80% after deductible
Prescription drugs (amount paid by member)[3]	
Preventive Rx medicines[12]	No cost when filled at a Humana-owned pharmacy (when filled at any other in-network pharmacy, subject to Rx4 cost share)
Tobacco-cessation medicines (including over the counter medicines when prescribed by a physician)	No Cost
Other medicines (Rx4)[13,14,15]	
• Level 1	$10 copay after deductible
• Level 2	$40 copay after deductible
• Level 3	$70 copay after deductible
• Level 4	25% coinsurance

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.

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

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

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

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

[5]Brand-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.

[7]Humana 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** 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.

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

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

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

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

[12]Preventive 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.

[13]If the cost of the drug is less than the required copay, the member will be responsible for the full cost of the prescription.

[14]The third and subsequent 30-day fills of any one maintenance medicine at a retail pharmacy will cost the member twice the applicable member cost share.

[15]Following 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): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك