Peña Employee Benefits

Licensed Benefit Consultant
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For all benefits available from:
November 1st 2022 – October 31st 2023

PEÑA FAMILY LLC.

health markets®

Best For Your Budget

Understanding the needs
of you and your family

Combining the products to give you the **best level** of coverage **for your budget**

- Health
- Supplemental
- Life
- Disability
- Long-Term Care
- Medicare
- Health & Wellness
- Association
- Retirement

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Medical Plan Options

1 Humana

Humana NPOS 21 On Hand/10050

DD	PPO	N/A
Doctor Visit	**No Charge - Telehealth**	
Specialist Visit	**No Charge - Telehealth**	
X-ray/Lab	**CYD, 0%**	
Imaging	**CYD, 0%**	
Urgent Care	**CYD, 0%**	
Emergency Room	**CYD, 0%**	
Hospital Stay	**CYD, 0%**	
Coinsurance		
Prescription Drugs	**$5/5/0/0/0**	
Deductible - Indiv / Family	**$7,900 / $15,800**	
Out-of-Pocket Max - Indiv / Family	**$7,900 / $15,800**	

GAP included!

TransConnect $6,000 Transamerica

Inpatient Benefit	**$6,000**
Outpatient Benefit, Inpatient Physician, ER	**$3,000**

2 Humana

Humana NPOS 16 COPAYF/5050

X	PPO	N/A
Doctor Visit	**$40**	
Specialist Visit	**$65**	
X-ray/Lab	**CYD, 50%**	
Imaging	**CYD, 50%**	
Urgent Care	**$100**	
Emergency Room	**CYD, 50%**	
Hospital Stay	**CYD, 50%**	
Coinsurance	**50%**	
Prescription Drugs	**$10/40/70/25%**	
Deductible - Indiv / Family	**$6,000 / $12,000**	
Out-of-Pocket Max - Indiv / Family	**$7,900 / $15,800**	

GAP included!

TransConnect $6,000 Transamerica

Inpatient Benefit	**$6,000**
Outpatient Benefit, Inpatient Physician, ER	**$3,000**

Transamerica Gap

- Inpatient Hospital Benefits $6,000
- Your policy pays benefits for inpatient hospital stays, inpatient procedures,
- inpatient physician charges, and even routine nursery care for dependent
- children. Your employer determines your calendar year maximum benefit
- (multiplied by three for an insured family).
- Outpatient Hospital Benefits $3,000
- Your policy also pays benefits (separate from the inpatient hospital
- benefits) for:
- >> radiological diagnostic testing performed in a hospital outpatient
- facility or a magnetic resonance imaging (MRI) facility
- >> radiation therapy or chemotherapy authorized by a radiologist,
- chemotherapist, or an oncologist for outpatient cancer treatment
- >> outpatient surgery performed in a hospital facility, free-standing
- surgery center, or physician's office
- >> MRIs, CT scans, PET scans, diagnostic ultrasounds, electrocardiogram (EKG) tests
- performed in a physician's office (x-rays and lab fees are not included)
- >> cardiac cauterizations and stress tests
- >> accident injury treatment in a hospital ER or urgent care center
- >> ER charges for illness if admitted to the hospital
- Ambulance Benefit
- This benefit pays up to $350 per calendar year for ground or air ambulance transportation
- provided by a licensed professional company within 72 hours of an accident or if you are
- hospitalized for the illness requiring the transportation

Plan 1 – On Hand

On Hand:

Preventive and everyday care at your fingertips

On Hand is a virtual-first health plan to fit the real world needs of modern businesses.

- ✓ Unlimited virtual preventive, routine, urgent, and mental healthcare for $0 with Doctor On Demand
- ✓ First plan of its kind to offer primary care from a phone, tablet, or computer

Humana

On Hand can make each day easier for your employees and more productive for your business

Instead of waiting weeks for appointments, your employees can get annual exams, review lab work, get prescriptions, and receive specialist referrals without ever setting foot in a waiting room.

- **Unlimited virtual preventive, routine, urgent, and mental healthcare** for $0 with Doctor On Demand (DOD)
- **In-person preventive care at no additional cost** for things like well-child and women's and men's health visits
- **Care kit** with blood pressure cuff, thermometer, and pulse oximeter to help doctors diagnose and manage member health
- **Pay only $5 for over 1,400 prescriptions and common labs**
- **Comparative prescription pricing** and GoodRx® access
- **Full-service care team** that members can request help scheduling appointments including finding a specialist and coordinating care
- **When members need to see a doctor in person,** they pay either a copay, or a percentage of the cost of a covered healthcare service after meeting the deductible, based on the plan
- **Go365® wellness** and rewards program*
- **On Hand mobile app** with access to member ID card, plan benefits, claims history, prescription pricing, and access to Doctor On Demand all in one place

Everyday care in a single tap with the On Hand app

Exclusively available with On Hand, members can:

- See a doctor – begin scheduled doctor visits or initiate an urgent care visit anytime 24/7
- Connect using their phone, tablet or computer.
- View and save ID card to photos
- View claims history and benefits
- View spending account balance
- Connect with the care team
- Get comparative prescription pricing by pharmacy and GoodRx

When employees enroll in the On Hand plan, providing their email address will ensure they receive important information on how to download the app and get to know their plan.

Meet Jennifer

Jennifer, 34, works for a cleaning and restoration company

On Hand provided Jennifer coordinated and continuous care through her Doctor On Demand primary care doctor visits for $0 each visit.

She had her first primary care appointment, lab results, a prescription, and a follow-up appointment within three days.

How it works: Primary & coordinated care

Jennifer's cost	Doctor On Demand (DOD) interaction
$0	Jennifer registered on the On Hand app & received her care kit
$0	Scheduled an annual check-up with her DOD doctor
$0	The care team helped her schedule her routine labs and in-person mammogram
$0	A few months later, she had a UTI and used her On Hand app to initiate an urgent care visit with DOD
$5 prescription	DOD prescribed an antibiotic for her UTI and sent it to her pharmacy for same-day pick up
$0	The care team checked in with Jennifer three days after her urgent care visit to see if she had any questions or concerns
$0	Jennifer was feeling overwhelmed with work and her personal life and needed to talk to someone; she scheduled and had a DOD appointment with a psychologist within three days

Example for illustrative purposes only

Meet Dan

Dan, 41, is a business owner of a small auto mechanic and welding shop.

He registered for DOD and scheduled an appointment when he needed care for his chronic condition.

Dan had his first appointment, lab results, a prescription, and a follow-up appointment within four days and a total cost of $10.

How it works: Chronic condition & specialist care

Dan's cost	Doctor On Demand (DOD) interaction
$0	Dan registered on the On Hand app and received his care kit
$0	Dan had his first appointment. He has a history of high cholesterol and blood pressure. His DOD doctor ordered a lipid panel
$5 lab	Dan went to a lab less than four miles from his home and was able to review the results through the DOD app the next day; this triggered Dan to have a follow-up appointment
$0	Dan had a visit with his DOD primary care doctor to discuss lab results and make a treatment plan. His doctor prescribed a statin for high cholesterol. During his visit, Dan mentioned he was struggling with an on-going shoulder injury, so his doctor recommended he see a specialist
$0	The DOD referral team contacted Dan the same day and scheduled a specialist appointment with an in-network orthopedist
$5 prescription	Dan picked up his high cholesterol statin prescription at his local pharmacy

Example for illustrative purposes only

Personalized care from anywhere

With a trusted doctor in their pocket, your employees will no longer have to travel for routine checkups. Now, your employees can get annual exams, manage chronic conditions, and have that cough checked out without waiting rooms or scheduling conflicts disrupting their day.

Benefit type	Description	ON HAND	Traditional HDHP w/included virtual visits
Virtual preventive & routine care visits	Virtual visits with Doctor On Demand	**$0 per visit (unlimited)**	Not available
Virtual urgent care visits	Urgent care visits with Doctor On Demand	**$0 per visit (unlimited)**	$56 per visit on average
Virtual psychiatry & psychology visits	Mental health visits with Doctor On Demand	**$0 per visit (unlimited)**	Coinsurance & deductible
Preventive care	Care kit	**$0**	Not available
	Vaccines, routine mammograms & prostate exams, well-child visits, chronic condition management, and more	**$0**	$0
	Care care team through Doctor On Demand	**$0**	Not available

through Doctor On Demand vs. in-person doctor for an initial primary care visit, scheduling labs and getting results

(Source: 1 Henry J. Kaiser Family Foundation, "Key Facts about the Uninsured Population," December 7, 2018 e)

Full-service coverage & straight forward pricing

On Hand includes all the features of a traditional High Deductible Health Plan (HDHP), but with two key cost-saving differences: Pay only $5 for most common prescriptions and labs.

Benefit type	Description	ON HAND	Traditional HDHP w/included virtual visits
Diagnostic lab & imaging	Common labs like Vitamin D, urinalysis and glucose testing	$5	Coinsurance after deductible
	MRI, CT scan, PET scan, and more	Coinsurance after deductible	Coinsurance after deductible
Prescription drugs	Tier 1 and 2	$5	Coinsurance after deductible
	Tier 3-5	Coinsurance after deductible	Coinsurance after deductible
In-person services	Office visits	Copay or coinsurance after deductible	Coinsurance after deductible
	Urgent care clinic and emergency room visits	Coinsurance after deductible	Coinsurance after deductible
	In-patient hospital and out-patient surgery	Coinsurance after deductible	Coinsurance after deductible

On Hand: Your employees are covered

Here's a look at examples of the wide range of care offered under the On Hand plan:

PRIMARY CARE

- Annual exams
- Well-baby and well-child visits
- Gynecology
- Immunizations
- Labs
- Prescriptions
- Mammograms and prostate exams
- Chronic condition management

URGENT CARE

- Colds and flu
- Respiratory infections
- Strep throat
- Stomach ailments
- Skin conditions
- UTIs

CARE SUPPORT

- Referrals to specialists
- Scheduling in-person care
- Mental health
- Weight management and nutrition
- Smoking cessation
- Coordination of care

Dental - Vision - Life

Dental Plan

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Humana PPO 100/80/50IN 80/50/50OUT INFS + Unlimited

PPO

Preventive / Basic / Major	**100% / 80% / 50%**
Endodontics	**80% Basic**
Periodontics	**80% Basic**
Deductible - Individual	**$50**
Deductible - Family	**$150**
Annual Maximum	**Unlimited**
Ortho Maximum - None	**Not Covered**
OON Reimbursement	**MAC**
Composite Filling	**Not Covered**
Implants	**Not Covered**
Waive Preventive Annual Max	**No**

Vision

1 Humana

Humana GN HUMANA VISION $10/15 COPAY $130 FRAME ALLOW $130 CONTACT ALLOW

INSIGHT

Exams	**12 months / $10 copay**
Lenses	**12 months / $130**
Frames	**24 months / $130**

Life Insurance

1 Humana

Humana BASIC LIFE/AD&D 2012 $25,000

Life Benefit	**$25,000**
AD&D Benefit	**$25,000**

Employee Premiums *Per Paycheck (Weekly)

Medical: Humana

Plan 1 On Hand

	Employee Cost	
Employee		No Cost
Employee/ Spouse	$	93.86
Employee/ Child(ren)	$	81.21
Family	$	199.63

Plan 2 Humana Buy Up

	Employee Cost	
Employee	$	20.57
Employee/ Spouse	$	134.99
Employee/ Child(ren)	$	120.29
Family	$	265.44

Dental: Humana

	Employee Cost	
Employee		No Cost
Employee/ Spouse	$	9.34
Employee/ Child(ren)	$	14.48
Family	$	23.81

Vision: Humana

	Employee Cost	
Employee		No Cost
Employee/ Spouse	$	1.50
Employee/ Child(ren)	$	1.35
Family	$	2.99

Life Insurance: Humana $25,000

	Employee Cost
Employee	No Cost

*all rates are based on final enrollment

Next Steps

- If you do nothing, you will be enrolled in Plan 1 Medical, Trans Gap, Dental, Vision and Life Employee only effective 11-1-22 at no cost to you!
- Contact Olga 480-912-1199 ofelix@penafamllc.com by Tuesday September 27th
  - If you want to add spouse and/or dependents
  - If you want to upgrade to Plan 2 and add spouse and/or dependents
  - If you want to DECLINE all coverage
    - If you have Medicaid, AHCCCS, Medicare or coverage through a spouse

480-524-1015

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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, visit www.groupcertificate.humana.com or by calling 866-4ASSIST (427-7478). 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 https://www.healthcare.gov/sbc-glossary/ or call 866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $7,900 individual / $15,800 family; Non-Network: $31,600 individual / $63,200 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?	Network Providers: Yes. Preventive Care and Certain Prescription Drugs Non-Network Providers: No.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, 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: $7,900 individual / $15,800 family For non-network providers: $36,600 individual / $73,200 family	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 doesn't cover, penalties for failure to obtain preauthorization for services, non-network transplant, non-network prescription drugs, non-network specialty drugs, non-network immune effector cell therapy	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. See www.humana.com/directories or call 866-4ASSIST (427-7478) for a list of network providers.	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). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	Non-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	Preferred network provider virtual visit: No charge; deductible does not apply Network provider virtual visit: No charge after deductible Primary care visit: No charge after deductible	Virtual visit: 50% coinsurance Primary care visit: 50% coinsurance	None
	Specialist visit	No charge after deductible	50% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	50% coinsurance	Imaging: Preauthorization may be required - if not obtained, penalty will be 50%.
	Imaging (CT/PET scans, MRIs)	No charge after deductible	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.humana.com/2022-Rx5-Blended	Level 1 - Preferred, lowest-cost generic drugs	(Retail) $5 copay/prescription; deductible does not apply (Mail Order) $12.50 copay/prescription; deductible does not apply	(Retail) 50% coinsurance (Mail Order) 50% coinsurance	(Retail) 30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% for certain prescription drugs. (Mail Order) 90 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% for certain prescription drugs.
	Level 2 - Low-cost generic drugs	(Retail) $5 copay/prescription; deductible does not apply (Mail Order) $12.50 copay/prescription; deductible does not apply	(Retail) 50% coinsurance (Mail Order) 50% coinsurance	
	Level 3 - Preferred brand-name drugs and higher-cost generic drugs	(Retail) No charge after deductible (Mail Order) No charge after deductible	(Retail) 50% coinsurance (Mail Order) 50% coinsurance	
	Level 4 - Non-preferred brand-name drugs and high-cost generic drugs	(Retail) No charge after deductible (Mail Order) No charge after deductible	(Retail) 50% coinsurance (Mail Order) 50% coinsurance	
	Level 5 - Highest-cost/high-technology drugs and specialty drugs	Network specialty pharmacy: No charge after deductible	(Retail) 50% coinsurance	30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% for certain prescription drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Physician/surgeon fees	No charge after deductible	50% coinsurance	None
If you need immediate medical attention	Emergency room care	No charge after deductible	No charge after network deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Emergency medical transportation	No charge after deductible	No charge after network deductible	
	Urgent care	No charge after deductible	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Physician/surgeon fees	No charge after deductible	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: No charge after deductible Outpatient hospital non-surgical services: No charge after deductible	Therapy: 50% coinsurance Outpatient hospital non-surgical services: 50% coinsurance	None
	Inpatient services	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
If you are pregnant	Office visits	No charge; deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge after deductible	50% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services.	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Rehabilitation services	Physical, occupational, speech, cognitive and audiology therapy: No charge after deductible	Physical, occupational, speech, cognitive and audiology therapy: 50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Habilitation services	Physical, occupational, speech and audiology therapy: No charge after deductible	Physical, occupational, speech and audiology therapy: 50% coinsurance	
	Skilled nursing care	No charge after deductible	50% coinsurance	60 days per year. Preauthorization may be required - if not obtained, penalty will be 50%.
	Durable medical equipment	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%. Excludes vehicle and home modifications, exercise, and bathroom equipment.
	Hospice services	No charge after deductible	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, if it is prescribed by a physician	• Cosmetic surgery, if for a congenital anomaly or to correct a functional impairment caused by injury, infection, disease	• Hearing aids, 1 hearing aid per ear every year
• Chiropractic care - spinal manipulations are covered	• Dental care (Adult), if for dental injury of a sound natural tooth	• Private-duty nursing, while hospital confined

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:

- www.humana.com or 866-4ASSIST (427-7478).
- Arizona Department of Insurance and Financial Institutions: 602-364-2499 or 800-325-2548 (outside Phoenix) or https://difi.az.gov/insurance.
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 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 on how 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:

- www.humana.com or 866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Arizona Department of Insurance and Financial Institutions: 602-364-2499 or 800-325-2548 (outside Phoenix) or https://difi.az.gov/insurance.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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:

Spanish (Español): Para obtener asistencia en Español, llame al 866-4ASSIST (427-7478) (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	$7,900
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,960**

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

The plan's overall deductible	$7,900
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,040**

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

The plan's overall deductible	$7,900
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

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, visit www.groupcertificate.humana.com or by calling 866-4ASSIST (427-7478). 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 https://www.healthcare.gov/sbc-glossary/ or call 866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $6,000 individual / $12,000 family; Non-Network: $18,000 individual / $36,000 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?	Network Providers: Yes. Certain Office Visits, Preventive Care, Emergency Room Care, Urgent Care, Prescription Drugs and Certain Therapies Non-Network Providers: Yes. Emergency Room Care 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. For example, 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: $7,900 individual / $15,800 family For non-network providers: $23,700 individual / $47,400 family	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 doesn't cover, penalties for failure to obtain preauthorization for services, non-network transplant, non-network prescription drugs, non-network specialty drugs, non-network immune effector cell therapy	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. See www.humana.com/directories or call 866-4ASSIST (427-7478) for a list of network providers.	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). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	Non-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	Telehealth or telemedicine services: $40 copay/office visit; deductible does not apply Primary care visit: $40 copay/office visit; deductible does not apply	Telehealth or telemedicine services: 50% coinsurance Primary care visit: 50% coinsurance	None
	Specialist visit	$65 copay/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	50% coinsurance	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	50% coinsurance	Cost sharing may vary based on where service is performed. Imaging: Preauthorization may be required - if not obtained, penalty will be 50%.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.humana.com/2022-Rx4/	Level 1 - Low-cost generic and brand-name drugs	(Retail) $10 copay/prescription; deductible does not apply (Mail Order) $25 copay/prescription; deductible does not apply	(Retail) 30% coinsurance, after $10 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $25 copay/prescription; deductible does not apply	(Retail) 30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug. (Mail Order) 90 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug.
	Level 2 - Higher-cost generic and brand-name drugs	(Retail) $40 copay/prescription; deductible does not apply (Mail Order) $100 copay/prescription; deductible does not apply	(Retail) 30% coinsurance, after $40 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $100 copay/prescription; deductible does not apply	
	Level 3 - High-cost, mostly brand-name drugs	(Retail) $70 copay/prescription; deductible does not apply (Mail Order) $175 copay/prescription; deductible does not apply	(Retail) 30% coinsurance, after $70 copay/prescription; deductible does not apply (Mail Order) 30% coinsurance, after $175 copay/prescription; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Level 4 - Highest-cost drugs	(Retail) 25% coinsurance; deductible does not apply (Mail Order) 25% coinsurance; deductible does not apply	(Retail) 30% coinsurance, after 25% coinsurance; deductible does not apply (Mail Order) 30% coinsurance, after 25% coinsurance; deductible does not apply	
	Specialty drugs	Preferred network specialty pharmacy: 25% coinsurance; deductible does not apply Network specialty pharmacy: 35% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$350 copay/visit; deductible does not apply	$350 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted.
	Emergency medical transportation	50% coinsurance	50% coinsurance after network deductible	
	Urgent care	$100 copay/visit; deductible does not apply	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $40 copay/visit; deductible does not apply Outpatient hospital non-surgical services: 50% coinsurance	Therapy: 50% coinsurance Outpatient hospital non-surgical services: 50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Inpatient services	50% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
If you are pregnant	Office visits	No charge; deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services.	50% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
	Rehabilitation services	Physical, occupational, speech, cognitive and audiology therapy: $65 copay/visit; deductible does not apply	Physical, occupational, speech, cognitive and audiology therapy: 50% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50%. For network, 60 visits per year combined. For non-network, 10 visits per year combined. Network and non-network visit limits reduce each other.
	Habilitation services	Physical, occupational, speech and audiology therapy: $65 copay/visit; deductible does not apply	Physical, occupational, speech and audiology therapy: 50% coinsurance	
	Skilled nursing care	50% coinsurance	50% coinsurance	60 day limit per year. Preauthorization may be required - if not obtained, penalty will be 50%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	50% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%. Excludes vehicle and home modifications,exercise and bathroom equipment.
	Hospice services	50% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, if it is prescribed by a physician
- Chiropractic care - spinal manipulations are covered
- Cosmetic surgery, if for a congenital anomaly or to correct a functional impairment caused by injury, infection, disease
- Dental care (Adult), if for dental injury of a sound natural tooth
- Hearing aids, 1 per ear per year
- Private-duty nursing, while hospital confined

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:

- www.humana.com or 866-4ASSIST (427-7478).
- Arizona Department of Insurance and Financial Institutions: 602-364-2499 or 800-325-2548 (outside Phoenix) or https://difi.az.gov/insurance.

Humana Dental PPO

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	If you use an IN-NETWORK dentist		If you use an OUT-OF-NETWORK dentist	
Calendar-year deductible (excludes orthodontia services)	Individual $50	Family $150	Individual $50	Family $150
	Deductible applies to all services excluding preventive services.			
Calendar-year annual maximum (excludes orthodontia services)	Unlimited			
Preventive services • Routine oral examinations (3 per year) • Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) • Routine cleanings (3 per year) • Periodontal cleanings (4 per year) • Fluoride treatment (1 per year, through age 16) • Sealants (permanent molars, through age 16) • Space maintainers (primary teeth, through age 15) • Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		80% no deductible	
Basic services • Emergency care for pain relief • Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) • Oral surgery (tooth extractions including impacted teeth) • Stainless steel crowns • Harmful habit appliances for children (1 per lifetime, through age 14)	80% after deductible		50% after deductible	
Major services • Crowns (1 per tooth every 5 years) • Inlays/onlays (1 per tooth every 5 years) • Bridges (1 per tooth every 5 years) • Dentures (1 per tooth ever 5 years) • Denture relines/rebases (1 every 3 years, following 6 months of denture use) • Denture repair and adjustments (following 6 months of denture use) • Implant Related Services (crowns, bridges, and dentures each limited to 1 per tooth every five years. Coverage limited to equivalent cost of a non-implant service. Implant placement itself is not covered.) • Periodontics (scaling/root planing and surgery 1 per quadrant every 3 years) • Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)	50% after deductible		50% after deductible	

Orthodontia services

Members may receive a discount on non-covered services of up to 20%. Members may contact their participating provider to determine if any discounts are available on non-covered services.

Non-participating dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in our network. If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee for covered services. If a member sees an out-of-network dentist, coinsurance will apply to the maximum allowable charge of one or more network providers in your geographic area. Out-of-network dentists may bill you for charges above the amount covered by your dental plan.

Waiting periods

Enrollment type	Group size	Preventive	Basic	Major [1]	Orthodontia [1]
Employer sponsored initial enrollment, open enrollment, and timely add-on	2-4 enrolled employees	No	No	12 months [2]	24 months [2]
Employer sponsored initial enrollment, open enrollment and timely add-on	5 or more enrolled employees	No	No	No	No
Voluntary initial enrollment, open enrollment, and timely add-on	2-9 enrolled employees	No	No	12 months [2]	24 months [2]
Voluntary initial enrollment, open enrollment, and timely add-on	10 or more enrolled employees	No	No	No	12 months [2]
Late applicant [3, 4]	2+ enrolled employees	No	12 months	12 months	12 months (24 months for 2-9 enrolled employees)

[1] Preventive Plus does not cover major and orthodontia services.
[2] Waiting periods may be decreased or waived based on the number of months the member had dental insurance immediately before their effective date. Members must have prior orthodontic insurance to reduce or waive the orthodontic waiting period.
[3] Late applicants not allowed with open enrollment option.
[4] Waiting periods do not apply to endodontic or periodontic services unless a late applicant.

Questions?

Simply call 1-800-233-4013 to speak with a friendly, knowledgeable Customer Care specialist, or visit **Humana.com**.

Feel good about choosing a Humana Dental plan

Make regular dental visits a priority

Regular cleanings can help manage problems throughout the body such as heart disease, diabetes, and stroke.* Your Humana Dental PPO plan focuses on prevention and early diagnosis, providing three routine cleanings, or four periodontal cleanings, along with three routine periodic exams per calendar year.
* www.perio.org

Go to MyDentalIQ.com

Take a health risk assessment that immediately rates your dental health knowledge. You'll receive a personalized action plan with health tips. You can print a copy of your scorecard to discuss with your dentist at your next visit.

Tips to ensure a healthy mouth:

- Use a soft-bristled toothbrush
- Choose toothpaste with fluoride
- Brush for at least two minutes twice a day
- Floss daily
- Watch for signs of periodontal disease such as red, swollen, or tender gums
- Visit a dentist regularly for exams and cleanings

Did you know that 74 percent of adult Americans believe an unattractive smile could hurt a person's chances for career success?* Humana Dental helps you feel good about your dental health so you can smile confidently.
* American Academy of Cosmetic Dentistry

Use your Humana Dental benefits

Find a dentist

With Humana Dental's PPO plan, you can see any dentist. Members and their families benefit from negotiated discounts on covered services by choosing dentists in the Humana Dental PPO Network. To find a dentist in Humana Dental's PPO Network, log on to **Humana.com** or call 1-800-233-4013.

Know what your plan covers

The other side of this page gives you a summary of Humana Dental benefits. Your plan certificate describes your Humana Dental benefits, including limitations and exclusions. You can find it on MyHumana, your personal page at **Humana.com** or call 1-800-233-4013.

See your dentist

Your Humana Dental identification card contains all the information your dentist needs to submit your claims. Be sure to share it with the office staff when you arrive for your appointment. If you don't have your card, you can print proof of coverage at **Humana.com**.

Learn what your plan paid

After Humana Dental processes your dental claim, you will receive an explanation of benefits or claims receipt. It provides detailed information on covered dental services, amounts paid, plus any amount you may owe your dentist. You can also check the status of your claim on MyHumana at **Humana.com** or by calling 1-800-233-4013.

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Limitations and Exclusions

In addition to the limitations and exclusions listed in Your plan benefits section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic procedures to include, but are not limited to:
   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
   - Any service to correct congenital malformation;
   - Any service performed primarily to improve appearance;
   - Characterizations and personalization of prosthetic devices; or
   - Any procedure to change the spacing and/or shape of the teeth.
7. Charges for:
   - Any type of implant and all related services;
   - Precision or semi-precision attachments;
   - Overdentures and any endodontic treatment associated with overdentures;
   - Other customized attachments;
   - Any service for 3D imaging (cone beam images);
   - Temporary and interim dental services;
   - Additional charges related to material or equipment used in the delivery of dental care.
   - Charges rendered for treatment in a clinical or dental facility sponsored or maintained by the employer.
   - The removal of any implants unless specified in the Summary of Your Benefits section of this certificate.
8. Any service related to:
   - Altering vertical dimension of teeth;
   - Restoration or maintenance of occlusion;
   - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth; Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   - Bite registration or bite analysis. Infection control, including but not limited to sterilization techniques.
9. Infection control, including but not limited to steralization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in Your plan benefits.
14. Any service that:
    - Is not eligible for benefits based upon clinical review;
    - Does not offer a favorable prognosis;
    - Does not have uniform professional acceptance; or
    - Is deemed to be experimental or investigational in nature.
15. Orthodontic services unless specified in your Summary of your benefits. Only the services specified in the orthodontic rider will be covered orthodontic benefits under this plan.

16. Any expense incurred before your effective date or after the date your coverage under this policy terminates (unless the service is eligible under Extension of benefits).
17. Charges exceeding the reimbursement limit for the service.
18. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
19. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
20. Temporary dental services.
21. Repair and replacement of orthodontic appliances.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
23. The oral surgery benefits under this plan does not include:
    a. Any services for orthognathic surgery;
    b. Any services for destruction of lesions by any method;
    c. Any services for tooth transplantation;
    d. Any services for removal of a foreign body from the oral tissue or bone;
    e. Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
    f. Any separate fees for pre and post-operative care.
24. General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services.
    General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
    1. Pain control unless a documented allergy to local anesthetic is provided.
    2. Anxiety.
    3. Fear of pain.
    4. Pain management.
    1. Emotional inability to undergo surgery. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
25. Preventive control programs including, but not limited too, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
26. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
27. Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
28. Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan.
29. We do not cover services that generally are considered to be medical services except those specifically noted as covered in this certificate.

Humana group dental plans are offered by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc., Humana Medical Plan of Utah, CompBenefits Company, CompBenefits Dental, Inc., Humana Employers Health Plan of Georgia, Inc. or DentiCare, Inc. (d/b/a CompBenefits).

This is not a complete disclosure of plan qualifications and limitations. Your agents will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

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Humana Vision 130

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Vision care services

	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging [1]	Up to $39	Not covered
Contact lens exam options [2]		
• Standard contact lens fit and follow-up	Up to $40	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames [3]	$130 allowance 20% off balance over $130	$65 allowance
Standard plastic lenses [4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Lens options [4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
– Tier 1	$57	Not covered
– Tier 2	$68	Not covered
– Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
– Tier 1	$110	Not covered
– Tier 2	$120	Not covered
– Tier 3	$135	Not covered
– Tier 4	$90 copay, 80% of charge less $120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses [5] (applies to materials only)		
• Conventional	$130 allowance, 15% off balance over $130	$104 allowance
• Disposable	$130 allowance	$104 allowance
• Medically necessary	$0	$200 allowance

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts may be available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or lenses for frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members may receive 20% off the retail price.

- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Questions?

Check out **Humana.com**
Call 1-866-995-9316 seven days a week:
8 a.m. to 6 p.m. Eastern Time
Monday through Saturday and
11 a.m. to 8 p.m. Sunday.

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Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York. In Arizona, group vision plans insured by Humana Insurance Company. In New Mexico, group vision plans insured by Humana Insurance Company.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana Basic Life

ARIZONA

Coverage	Loss	Benefit
Life insurance	Death	Your beneficiary will receive $25,000.
Accelerated death benefit	Terminal illness with a life-expectancy of 24 months or less. You must have continuous coverage a minimum of six months in order to qualify.	50 percent of the life benefit amount to a maximum benefit of $250,000. The final life benefit amount will be reduced by the amount of the accelerated death benefit paid (may vary by state).
Accidental death or bodily injury (AD&D)	Death as the result of an accident.	Your beneficiary will receive $25,000.
	As the result of an accident, loss of: both hands or feet; sight of both eyes; one hand and one foot; one hand or one foot and sight of one eye; complete paralysis (quadriplegia)	You will receive $25,000.
	As the result of an accident, loss of: one hand; one foot; sight of one eye; loss of thumb and index finger of same hand; partial paralysis (paraplegia and hemiplegia)	50 percent of the life benefit amount.
AD&D includes the following benefits:		
Common carrier benefit	Death or dismemberment as a fare paying passenger	200 percent of life benefit amount
Seat belt-airbag-helmet benefit	Death as the result of an auto accident while properly using a seat belt, or wearing a properly fitted and fastened motorcycle helmet in a motorcycle accident.	Amount of your accidental death benefit increases by 10 percent, but not less than $1,000 or more than $10,000. In addition, we will increase your accidental death benefit by 5 percent, to a maximum of $5,000 but no less than $500, for a properly functioning airbag.
Education benefit	Death as the result of an accident.	Actual expense to a maximum of $5,000 or 5 percent of death benefit. Payable up to four years for employee's dependent children or until age 25. Dependent must be a full-time student beyond 12th grade at a college, university or vocational school on the date of the employee's death or within 365 days after the death.
Childcare benefit	Death as the result of an accident.	Actual expense to a maximum of $5,000 or 5 percent of death benefit. For a dependent in a licensed childcare center up to four consecutive years after the employee's death, or until the child's 13th birthday.

AD&D includes the following benefits:

Coma benefit	Employee is in a coma caused by a body injury, the coma begins within 365 days after the accident; and the person remains in a coma for more than 31 consecutive days	One time payment of 5 percent of the employee's benefit, subject to a maximum of $5,000.
Repatriation benefit	Death as the result of an accident.	Actual expenses to a maximum of $5,000 if employee dies as a result of an accidental death at least 150 miles from his/her principal place of resident, and there are expenses for preparing and transporting the employee's body to a mortuary.
Spouse training benefit	Death as the result of an accident.	Actual expense to a maximum of $5,000 or 5 percent of death benefit for one year after the employee's death. Survivor must be enrolled as a student in an accredited school on the date of the employee's death or within 365 days after the death.

Coverage	Loss	Benefit
Dependent insurance	Death of spouse Death of dependent child*	No dependent coverage selected. No dependent coverage selected.

*Some limitations apply.

Age reduction schedule

Beginning at age 65 (or age 70 in schedule three), employee life coverage will reduce based on the benefit amount in force on the employee's 64th birthday (or age 69 in schedule three). Basic Dependent Spouse Life terminates at age 65.

Age	Schedule two
65	35 percent
70	50 percent
75	No further reduction
80	
85+	

Rate guarantee

Rate is guaranteed not to change for two years (or three years, if offered) from the effective date of the policy.

Eligibility to participate

Active, full-time employees are eligible for coverage.

Waiver of premium

If you are totally disabled for at least six consecutive months prior to age 60, you can continue life insurance coverage and waive the premium. Waiver ends at age 65.

Conversion privilege

If your employment ends, you may be eligible to convert your coverage to an individual whole life insurance policy.

How much life insurance do you need?

The real question is:

How much will your loved ones need for short- and long-term expenses?

According to the American Council of Life Insurers (ACLI), a guideline is a life insurance amount equal to 10 times your annual income. No rule applies to everyone, however, because financial situations and goals vary from person to person and family to family. Use our simple online life insurance calculator at Humana.com to help determine your life insurance needs.

Questions?

Check out **Humana.com**

Call 1-800-233-4013 anytime for automated information or 8 a.m. to 6 p.m. for a customer service representative.

Insured by Humana Insurance Company or Humana Insurance Company of Kentucky. In Arizona, group life plans insured by Humana Insurance Company. In New Mexico, group life plans insured by Humana Insurance Company.

This is not a complete disclosure of plan qualifications and limitations. Please review your Certificate of Insurance for a complete list of benefits. The Certificate of Insurance is the document upon which eligibility and benefit payment will be determined. Your agent/broker will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage.

Humana®

Policy Number: GN-70050-07 EM POLICY 5/06 et.al.

Plan summary created on: 9/21/22 18:00