

Humana Health Plans of Puerto Rico, Inc.

<https://feds.humana.com/>

Customer Service 1-800-314-3121 option 1 and then option 2

2022

A Health Maintenance Organization with a Point of Service Product

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See page 13.

Serving: The Commonwealth of Puerto Rico

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Enrollment codes for this Plan:

ZJ1 Self Only

ZJ3 Self Plus One

ZJ2 Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2022: Page 15
- Summary of Benefits: Page 77



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Healthcare and Insurance
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RI 73-820

**Important Notice from Humana Health Plans of Puerto Rico, Inc. About
Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that Humana Health Plans of Puerto Rico, Inc. prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213, TTY: 1-800-325-0778.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of Humana Health Plans of Puerto Rico, Inc., under contract (CS 2872) between Humana and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 1-800-314-3121 option 1 and then option 2 or through our website: <https://feds.humana.com/>. The address for the Humana Health Plans of Puerto Rico, Inc. administrative office is:

Humana Health Plans of Puerto Rico, Inc.
383 F.D. Roosevelt Avenue
San Juan, Puerto Rico 00918-2131

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2022, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2022, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Humana Health Plans of Puerto Rico, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 1-877-499-7295 and explain the situation.
- If we do not resolve the issue:

**CALL - THE HEALTHCARE FRAUD HOTLINE
1-877-499-7295**

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

**You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
 - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Humana Health Plans of Puerto Rico, Inc. complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-314-3121, TTY 711.**

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-314-3121, TTY 711.**

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-314-3121, TTY 711.**

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-314-3121, TTY 711.**

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-314-3121, TTY 711.**

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-314-3121, TTY 711.**

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-314-3121, TTY 711.**

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-314-3121, TTY 711.**

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider’s portal?
- Don’t assume the results are fine if you do not get them when expected Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic .

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
 - "Exactly what will you be doing?"
 - "About how long will it take?"
 - "What will happen after surgery?"
 - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use Humana preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation** We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Minimum essential coverage (MEC)** Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
- **Minimum value standard** Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
- **Where you can get information about enrolling in the FEHB Program** See www.opm.gov/healthcare-insurance for enrollment information as well as:
 - Information on the FEHB Program and plans available to you
 - A health plan comparison tool
 - A list of agencies that participate in Employee Express
 - A link to Employee Express
 - Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next Open Season for enrollment begins

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

Once enrolled in your FEHB Program Plan, you should contact Humana directly for address updates and questions about your benefit coverage.

- **Types of coverage available for you and your family** Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to obtain a Certificate of Creditable Coverage (COCC) or to add a dependent when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a newborn if you currently have a Self Only plan.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one eligible family member as described in the chart below.

Natural children, adopted children, and stepchildren

Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children

Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support

Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children

Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance

Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children’s Equity Act**

OPM has implemented the Federal Employees Health Benefits Children’s Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2022 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan’s 2021 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension

You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 1-800-4HUMANA or visit our website at <https://humana.com>.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Humana holds the following accreditations: Utilization Review Accreditation Commission (URAC). To learn more about this plan's accreditation(s), please visit the following websites: www.URAC.org.

We require you to see specific physicians, hospitals, and other providers that contract with us. These plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General Features of our High Option

We have Point of Service (POS) benefits

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than \$7,000 for Self Only enrollment, and \$14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance/) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Locally, Humana Health Plans of Puerto Rico, Inc. has been in existence since 1983.
- Nationally, Humana has been in the healthcare business since 1961.
- Humana is a for profit corporation which is publicly traded on the New York Stock Exchange (NYSE).

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, <http://feds.humana.com>. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 1-800-314-3121 option 1 and then option 2 , or write to the Plan at 383 F.D. Roosevelt Avenue, San Juan, Puerto Rico 00918-2131. You may also visit our website at www.humana.pr.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at <http://feds.humana.com> to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

The entire island of Puerto Rico.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2022

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes:

- Effective in 2022, premium rates are the same for Non-Postal and Postal employees.

Changes to this Plan:

- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. (See page 78)
- Skilled Nursing: Plan currently provides 30 days at no cost to the member. However, members will be able to obtain up to an additional 30 days at no cost, with Plan approval, for up to a maximum of 60 days per plan year.

Section 3. How You Get Care

Identification cards	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-314-3121 option 1 and then option 2 or write to us at Humana Health Plans of Puerto Rico, 383 F.D. Roosevelt Avenue, San Juan, Puerto Rico 00918-2131. You may also request replacement cards through our website at https://feds.humana.com/ at the MyHumana portal.</p>
Where you get covered care	<p>You get care from “Plan providers” and “Plan facilities”. You will only pay copayments, deductibles, and/or coinsurance, if you use our point-of-service program. You can also get care from non-Plan providers but it will cost you more.</p>
<ul style="list-style-type: none">• Plan providers	<p>Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our website at https://feds.humana.com/, at the Physician Finder portal.</p> <p>This plan recognizes that transsexual, transgender, and gender-nonconforming members require health care delivered by healthcare providers experienced in transgender health. While gender reassignment surgeons (benefit details found in Section 5(b)) and hormone therapy providers (benefit details found in Section 5(f)) play important roles in preventive care, you should see a primary care provider familiar with your overall health care needs. Benefits described in this brochure are available to all members meeting medical necessity guidelines.</p>
<ul style="list-style-type: none">• Plan facilities	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website at https://feds.humana.com/, at the Physician Finder portal.</p>
Balance Billing Protection	<p>FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, coinsurance) contact Humana to enforce the terms of its provider contract.</p>
What you must do to get covered care	<p>It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your healthcare. You may choose your primary care physician from our Provider Directory or our website, or you may call us for assistance.</p>
<ul style="list-style-type: none">• Primary care	<p>Your primary care physician can be a family practitioner, general practitioner, internist, or pediatrician. Your primary care physician will provide most of your healthcare, or give you a referral to see a specialist. However, a woman may see her plan gynecologist without a referral.</p>

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us; 1-800-314-3121 option 1 and then option 2. We will help you select a new one.

- **Specialty care**

You may see any participating specialist without a referral, including:

- Mental health providers
- Vision care providers
- OB/GYN providers for your annual well-woman exam
- Another doctor your primary care physician has designated to provide patient care when he or she is not available.

Here are some other things you should know about specialty care:

If your current specialist does not participate with us, you must receive treatment from a specialist who does. We will not pay for you to see a specialist who does not participate with our Plan.

- If you have a chronic and disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause;
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
 - reduce our Service Area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-314-3121 option 1 and then option 2. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

If you do not have a primary care physician and you use non-plan providers, you need to obtain our approval before you receive certain services. The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a denial or reduction of benefits if you do not obtain precertification, prior approval or a referral. The pre-service claim approval process will be arranged by your provider and only applies to care shown under *Other services*.

• **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

• **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Services outside the service area – not emergencies
- Organ/tissue transplants
- All elective medical and surgical hospitalizations
- Non-emergent admissions for mental health, skilled nursing, acute rehabilitation facilities and long term acute care facilities
- MRI, MRA, PET, CT Scan, SPECT Scan
- Surgical treatment for morbid obesity
- All durable medical equipment (DME) over \$750
- Home healthcare services
- Infertility services
- Some specialty drugs when delivered in the physician's office, clinic, outpatient or home setting
- Oral surgeries
- Growth Hormone therapy
- Genetic/Molecular Diagnostic Testing – (Genetic testing is covered under the laboratory services benefit, limitations may apply.)
- Radiation Therapy
- Esophagogastroduodenoscopy(EGD)
- Coronary angiography
- Colonoscopy repeat testing

For a complete listing of services requiring prior authorization, please visit our website at <https://www.humana.com/>.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative must call us at 1-800-314-3121 option 1 and then option 2 or in the metro area 787-282-7900, extensions 5550 or 5599 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;

- name of hospital or facility; and
- number of days requested for hospital stay.

• **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days, from the receipt of the notice to provide the information.

• **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-314-3121. You may also call OPM's Health Insurance 3 at 1-(202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-314-3121. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

• **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **The Federal Flexible Spending Account Program - FSAFEDS**
- **HealthCare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

• **Emergency inpatient admission** If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

• **Maternity care** Precertification is not required for maternity care.

• **If your treatment needs to be extended** If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities When services are rendered by non-Plan providers, the member will pay for all of the services and request reimbursement from Humana. Reimbursement will be based on the rate contracted by Humana for those services less the corresponding copayment or coinsurance. The member will also be responsible for satisfying the \$100 for Self Only, or \$300 for Self and Family annual deductible. For out of area non-emergency services that are not coordinated with Humana, a coinsurance of 20% of the allowable fee up to \$2,000 will apply.

Circumstances beyond our control Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

• **To reconsider a non-urgent care claim** Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60, days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.

Copayments A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of \$5 per office visit.

Deductible A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. A deductible applies only if you access non-plan providers under the Point of Service Option – see Section 5(i). Copayments do not count toward any deductible.

- The calendar year deductible is \$100 per person under the High Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach \$100 under the High Option. Under a Self Plus One or Self and family enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach \$300 under High Option.

Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: In our Plan, you pay 50% of our allowance for durable medical equipment.

Differences between our Plan allowance and the bill You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum After your (copayments and coinsurance) total \$4,000 for Self Only, or \$8,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of \$4,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a \$4,000 Self Only maximum out-of-pocket limit and an \$8,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$4,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$8,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$4,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

There is a separate maximum out-of-pocket limit of \$4,000 for Self Only and \$8,000 for a Self Plus One or Self and Family enrollment for utilizing out-of-network providers.

Be sure to keep accurate records and receipts of your copayments and coinsurance since you are responsible for informing us when you reach the maximum is reflected accurately.

Carryover

If you changed to this plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against “surprise billing” and “balance billing” under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

In addition, your health plan adopts and complies with the surprise billing laws of Puerto Rico.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to <https://humana.com> or contact the health plan at 1-800-4HUMANA.

Section 5. High Option Benefits

See page 15 for how our benefits changed this year. Page 77 is a benefits summary of the High Option. Make sure that you review the benefits that are available under the High Option.

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Section 5. High Option Point of Service (POS) Option Benefits Overview

This Plan offers a Point of Service (POS) Option. All benefit packages are described in Section 5. Make sure that you review the benefits that are available under the High Option in which you are enrolled.

The POS Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about POS Option benefits, contact us at 1-800-4HUMANA or on our website at <https://feds.humana.com/>.

Network Availability

Humana contracts with both private office physicians and with physician groups. Your primary care physician will provide most of your healthcare, or give you a referral to see a specialist. However, a woman may see her plan gynecologist without a referral. The Puerto Rico plan will utilize the POS network.

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Online tools include:

- Newly hired employees can easily navigate their plan choices
- Ability to view benefits and rates available to you based on service area ZIP code
- Learn “What’s New” about Humana’s plan offerings and other health topics
- Enroll in medical plans online
- Educate yourself about Humana’s health and wellness programs
- Find in-network doctors, hospitals and pharmacies near you
- Search Humana’s Drug List for prescription drugs and their estimated retail prices

**Section 5(a). Medical Services and Supplies
Provided by Physicians and Other Healthcare Professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$100 per person (\$300 per Self Plus One enrollment, or \$300 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • Office medical consultations • Second surgical opinion • Advance care planning 	\$5 copay per office visit
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing
<ul style="list-style-type: none"> • At home 	\$15 copay per visit
Telehealth services	High Option
<p>Telemedicine (also known as “telehealth” or “video visits”) uses information technology and telecommunications to provide virtual clinical care to patients. Patients can interact with providers through video and app technology by using smartphones, tablets, and laptops.</p> <p>With Humana's telemedicine benefit delivered by MDLIVE, you can:</p> <ul style="list-style-type: none"> • Immediately see a doctor 24 hours a day, 7 days a week from any location • Your primary care physician can access your telemedicine visit at your request • If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy <p>Note: MDLIVE telemedicine services excludes mental health and substance abuse. Members may access virtual visits through in-network providers who offer behavioral health services with a previous appointment at a \$5 copay. <i>See Section 5(e) Mental Health and Substance Use Disorder Benefits.</i></p>	\$10 copay per visit

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	High Option
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG • Coronary angiography (Note: See You need prior plan approval for certain services in Section 3) 	Nothing
<p>Other tests:</p> <ul style="list-style-type: none"> • Genetic counseling and Genetic testing when medically necessary. (Note: See <i>You need prior plan approval for certain services</i> in Section 3) 	<p>\$5 copay per office visit</p> <p>\$25 copay per outpatient hospital or surgical center visit</p>
Preventive care, adult	High Option
<p>Routine physical every year</p> <p>The following preventive services are covered at the time interval recommended at each of the links below:</p> <ul style="list-style-type: none"> • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • Low dose CT scan (for lung cancer screening) • To build your personalized list of preventive services go to https://health.gov/myhealthfinder 	Nothing
<ul style="list-style-type: none"> • Routine mammogram – covered for women 	Nothing
<ul style="list-style-type: none"> • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	Nothing

Benefit Description	You pay
Preventive care, adult (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges</i>
Preventive care, children	High Option
<ul style="list-style-type: none"> • Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U. S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org <p>Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p>	Nothing
Maternity care	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Screening for gestational diabetes for pregnant women • Delivery • Postnatal care 	Nothing
<p>Breastfeeding support, supplies and counseling for each birth</p> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your vaginal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay for you and/or your baby, if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). • We offer Humana<i>Beginnings</i>. See <i>Special features</i> in Section 5(h). 	Nothing

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	High Option
<p>Note: When a newborn requires definitive treatment during or after the mother’s confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p>	Nothing
Family planning	High Option
<ul style="list-style-type: none"> • Contraceptive counseling on an annual basis <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures, Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> 	<i>All charges</i>
Infertility services	High Option
<p>Infertility is the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For women without male partners or exposure to sperm, infertility is the inability to conceive after six cycles of Artificial Insemination or Intrauterine Insemination performed by a qualified specialist using normal quality donor sperm. These 6 cycles (including donor sperm) are not covered by the plan as a diagnosis of infertility is not established until the cycles have been completed.</p> <p>Covered benefits including evaluation and treatment:</p> <p>Females - ovulation evaluation, tubal patency, hormonal evaluation, and cervical factor evaluation.</p> <p>Males – includes sperm analysis, hormonal analysis, sperm functioning and medical imaging. Treatment would include correction of any defect found in the evaluation of both male and female partners.</p> <p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs are covered under the prescription drug benefit. See <i>You need prior plan approval for certain services</i> in Section 3.</p>	\$5 copay per office visit

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>In vitro fertilization (IVF)</i> - <i>Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>
Allergy care	High Option
Testing and treatment	\$5 copay per office visit
<ul style="list-style-type: none"> • Allergy serum • Allergy injections 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing and sublingual allergy desensitization</i> 	<i>All charges</i>
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy (Note: See <i>You need prior plan approval for certain services</i> in Section 3) <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 38.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided at no visit limit • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV) / Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the Prescription Drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. Your Plan Physician will ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Section 3 under <i>Other services</i> under <i>You need prior Plan approval for certain services</i> on page 18.</p> <p>Note: Applied Behavior Analysis (ABA) children with Autism Spectrum Disorder benefit is covered under Section 5(e) - Mental and Substance Abuse benefits. See Section 3 under <i>Other services</i> under <i>You need prior Plan approval for certain services</i> on page 18.</p>	Nothing

Benefit Description	You pay
Physical and occupational therapies	
<p>60 visits per year per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges</i>
Habilitative Services	
60 visits per year per condition for the services of habilitative services	Nothing
Speech therapy	
60 visits per year	Nothing
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist 	\$5 copay per office visit
<ul style="list-style-type: none"> • For routine hearing screening performed during a child's preventive care visit, See Section 5(a) <i>Preventive care, children</i> 	Nothing
<ul style="list-style-type: none"> • Cochlear Implants <p>Note: For benefits for the devices, see Section 5(a) <i>Orthopedic and prosthetic devices</i></p>	50% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing services that are not shown as covered</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	\$5 copay per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>

Benefit Description	You pay
Foot care	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	\$5 copay per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	High Option
<ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) <i>Surgical procedures</i>. For information on the hospital and/ or ambulatory surgery center benefits, see Section 5(c) <i>Services provided by a hospital or other facility, and ambulance services</i>.</p>	50% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, heel pads, heel cups, corsets and trusses</i> • <i>Arch supports, foot orthotics except for diabetes and hammer toe</i> • <i>Elastic stockings, support hose, and other supportive devices not custom made</i> • <i>Prosthetic replacements except as required by growth or change in medical condition, or in the case where the medically necessary repair exceeds the cost replacement or normal wear and tear renders the device nonfunctional and non-repairable</i> 	<i>All charges</i>
Durable medical equipment (DME)	High Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and maintenance of purchased medical equipment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Insulin pumps and supplies • Blood glucose monitors • Communication devices 	50% of covered services

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	High Option
<p>Note: Communication devices covered for members who have had surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.</p> <p>Note: Call us at 1-866-488-5992 or metro area 787-282-7900 extensions 5550 or 5599 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p> <p>Note: Preauthorization is necessary for items over \$750. See <i>You need prior plan approval for certain services</i> in Section 3.</p>	50% of covered services
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Equipment such as exercise equipment, air cleaners, heating pads or lights and bed lifts, hearing aids and personnel hygiene equipment.</i> • <i>Communication devices except for those members who have had surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.</i> 	<i>All charges</i>
Home health services	High Option
<ul style="list-style-type: none"> • Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. <p>Note: See <i>You need prior plan approval for certain services</i> in Section 3. Authorization must be renewed at the ending period of sixty (60) days.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Private duty nurse</i> 	<i>All charges</i>
Chiropractic	High Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities <p><i>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</i></p> <p>Note: Limited to 15 visits per member per calendar year.</p>	\$5 copay per office visit
Alternative treatments	High Option
No benefit	<i>All charges</i>
Educational classes and programs	High Option
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> • Tobacco Cessation programs, including individual, group, phone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence • Childhood obesity education 	<p>Nothing for counseling for up to two quit attempts per year.</p> <p>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.</p>
<ul style="list-style-type: none"> • Diabetes self management 	\$5 copay per office visit

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$100 per person (\$300 per Self Plus One enrollment, or \$300 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment for morbid obesity (bariatric surgery). (Note: See You need prior plan approval for certain services in Section 3). Some of the requirements that must be met before surgery can be authorized are: <ul style="list-style-type: none"> - Patient is 18 years of age or older - Body Mass Index of >40, or a Body Mass Index of >35 with associate comorbidity such as: <ul style="list-style-type: none"> • Hypertension • Type two diabetes • Life-threatening cardiopulmonary problems - Physician's documentation which indicates that you have had unsuccessful attempt(s) with nonoperative medically- supervised weight-reduction program (s) • Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g. tubal ligation, vasectomy) 	<p>\$5 copay per office visit</p> <p>Nothing for hospital visits</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> • Treatment of burns • Esophagogastroduodenoscopy (EGD) (Note: See You need prior plan approval for certain services in Section 3) • Colonoscopy repeat testing (Note: See You need prior plan approval for certain services in Section 3) <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$5 copay per office visit</p> <p>Nothing for hospital visits</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the feet; (See 5(a) Foot care)</i> 	<p><i>All charges</i></p>
Reconstructive surgery	High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and that is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Orthopedic and Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> <ul style="list-style-type: none"> • Gender reassignment surgery performed to change primary and/or secondary sex characteristics <ul style="list-style-type: none"> - Surgical treatment for gender reassignment is limited to the following: <ul style="list-style-type: none"> • For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy • For male to female surgery: penectomy, orchiectomy <p>Note: You must be 18 years or older to be considered for genital reconstruction surgery. There are pre-surgical requirements for members considering gender reassignment surgery including but not limited to: a documented diagnosis of gender dysphoria, 12 months of hormone therapy as appropriate to the individual gender goals, and referral letters from a mental health specialist.</p>	<p>\$5 copay per office visit</p> <p>Nothing for hospital visits</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury (Note: See You need prior plan approval for certain services in Section 3)</i> • <i>Any surgical procedure for gender reassignment not listed above</i> 	<i>All charges</i>
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$5 copay per office visit</p> <p>Nothing for hospital visits</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>
Organ/tissue transplants	High Option
<p>These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See <i>Other services</i> under <i>You need prior Plan approval for certain services</i> on page 18. These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	<p>Nothing</p>
<p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi’s, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfillippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer 	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Ependyoblastoma - Epithelial ovarian cancer - Ewing’s sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors 	<p>Nothing</p>
<p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi’s, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma 	<p>Nothing</p>
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p>	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient’s condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Aggressive non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Aggressive non-Hodgkin’s lymphoma 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis <p>Benefits are available for Allogeneic and Autologous blood or marrow stem cell transplants utilizing a phase two or higher protocol.</p> <p>National Transplant Program (NTP) - all services are determined and authorized through our transplant department, utilizing our National Transplant Network.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or bone marrow/stem cell transplant donors in addition to the testing of family members.</p> <p>See <i>You need prior plan approval for certain services</i> in Section 3.</p>	<p>High Option</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except as shown above • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
<p>Anesthesia</p>	<p>High Option</p>
<p>Professional services provided in -</p> <ul style="list-style-type: none"> • Office 	<p>\$5 copay per office visit</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	<p>Nothing</p>

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. the calendar year deductible is \$100 per person (\$300 per Self Plus One enrollment, or \$300 per Self and Family enrollment).
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your cost for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- **Observation Care:** Your share for hospital observation care that exceeds 24 hours is the same as inpatient hospital care. Observation Care below 24 hours is the same as the Emergency Room benefit/copy.

Benefit Description	You pay High Option
<p>Inpatient hospital</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	Nothing
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as phone, television, barber services, guest meals and beds • Private nursing care, except when medically necessary • Blood and blood components not replaced by the member 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>\$25 copay for outpatient surgery</p>
<ul style="list-style-type: none"> • Other outpatient non-surgical care such as mammograms, laboratory tests and x-rays 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Blood and blood derivatives not replaced by the member. 	<p><i>All charges</i></p>
Extended care benefits/Skilled nursing care facility benefits	High Option
<ul style="list-style-type: none"> • Skilled nursing facility (SNF): minimum of thirty (30) days; 30 additional days, with Plan approval, up to a maximum of 60 days per plan year <p>See <i>You need prior plan approval for certain services</i> in Section 3</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care 	<p><i>All charges</i></p>
Hospice care	High Option
<ul style="list-style-type: none"> • Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care up to 180 days. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Independent nursing, homemaker services 	<p><i>All charges</i></p>

Benefit Description	You pay
End of life care	High Option
Personal Nurse provides the following end-of-life support: <ul style="list-style-type: none"> • Hospice coordination • Education and support services • Humana At Home Coordination 	Nothing
Ambulance	High Option
Local professional ambulance service when medically appropriate	\$25 copay
Between hospital facilities	Nothing
Air ambulance	\$50 copay

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$100 per person (\$300 per Self Plus One enrollment, or \$300 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **Observation Care:** Your share for hospital observation care that exceeds 24 hours is the same as inpatient hospital care. Observation Care below 24 hours is the same as the Emergency Room benefit/copy.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 phone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if a delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	High Option
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$5 copay per office visit
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$25 copay per visit
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$50 copay per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> 	<i>All charges</i>
Emergency outside our service area	High Option
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$5 copay per office visit
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$25 copay per visit
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital</p>	\$50 copay per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>
Telehealth services	High Option
<p>Telemedicine (also known as “telehealth” or “video visits”) uses information technology and telecommunications to provide virtual clinical care to patients. Patients can interact with providers through video and app technology by using smartphones, tablets, and laptops.</p> <p>With Humana's telemedicine benefit delivered by MDLIVE, you can:</p> <ul style="list-style-type: none"> Immediately see a doctor 24 hours a day, 7 days a week from any location Your primary care physician can access your telemedicine visit at your request If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy 	\$10 copay per visit
Ambulance	High Option
<ul style="list-style-type: none"> Professional ambulance service when medically appropriate <p>Note: See Section 5(c) for non-emergency service.</p>	\$25 copay
Between hospitals	Nothing
Air ambulance	\$50 copay

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$100 per person (\$300 per Self Plus One enrollment, or \$300 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR MENTAL HEALTH PROFESSIONAL MUST GET CERTIFICATION FOR SOME MENTAL HEALTH VISITS AND SERVICES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	High Option
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions; the cost amount may be determined by the place of service.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider’s office or other professional setting • Electroconvulsive therapy 	\$5 copay per visit

Benefit Description	You pay
Diagnostics	High Option
<ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility 	Nothing
Inpatient hospital or other covered facility	High Option
<p>Inpatient services provided and billed by a hospital or other covered facility, including residential facilities</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services 	Nothing
Outpatient hospital or other covered facility	High Option
<p>Outpatient services provided and billed by a hospital or other covered facility, including residential facilities</p> <ul style="list-style-type: none"> • Services in approved treatment programs, such as partial hospitalization or full-day hospitalization or facility-based intensive outpatient treatment 	Nothing
Applied behavior analysis (ABA) therapy	High Option
Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	Nothing
Other services	High Option
<ul style="list-style-type: none"> • Urgent Care • Nutritional Counseling for Eating Disorders • Physical, Occupational, Speech and Habilitative therapies for Mental Health (Unlimited visits) (Note: See <i>You need prior plan approval for certain services</i> in Section 3) • Skilled Nursing Facilities (Unlimited visits) • Telemedicine <p>Note: Members may access virtual visits through in-network providers who offer behavioral health services with a previous appointment (this does not include MDLIVE providers).</p>	\$5 copay per visit
Not covered	High Option
<i>Services that are not part of a preauthorized approved treatment plan</i>	<i>All charges</i>

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$100 per person (\$300 per Self Plus One enrollment, or \$300 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a prescribed maintenance medication. Maintenance medications are drugs that are generally prescribed for the treatment of long term chronic sicknesses or injuries.
- **The Rx4 Plan** allows members access to any drug that is used to treat a condition the medical plan covers. Thousands of drugs have been placed in levels based on their a) efficacy, b) safety, c) possible side effects, d) drug interactions, and e) cost compared to similar drugs. New drugs are continually reviewed for level placement, dispensing limits and prior authorization requirements that represent the current clinical judgment of our Pharmacy and Therapeutics Committee.

Level One contains/covers the lowest copayment for low-cost generic and brand-name drugs.

Level Two contains/covers higher cost generic and brand-name drugs.

Level Three contains/covers higher cost drugs, mostly brand names. These drugs may have generic or brand-name options on Levels One or Two that may save you money.

Level Four contains/covers most self administered injectable medications and high technology drugs that are often newly approved by the U.S. Food and Drug Administration.

With **Rx4** the member takes on more of the cost share for the drug. In return, members receive access to more drugs to treat their conditions and have more choices, along with their physicians, to decide which drug to take. Members receive letters offering guidance in changing medications to those with a lower copayment. We use internal data to identify members for whom a less expensive prescription drug option may be available. We communicate the information to the member to enable them, along with their physician, to make an informed choice regarding prescription drug copayment options.

- **Prior Authorization** – Some medications need special monitoring and may require prior authorization. These drugs have different approval criteria based on indication, safety, and appropriate use. Prior authorization (PA) requires a physician to obtain pre-approval in order to provide coverage for a drug prescribed to a member.
- **Step Therapy:** Step Therapy directs therapy to the most cost-effective and safest drug available to be used prior to moving to a more costly or risky therapy. Step Therapy is an automated process and requires the member to try alternative medications before the more costly medications are considered.

- **These are the dispensing limitations.** Prescription drugs dispensed at a Plan pharmacy will be dispensed for up to a 30-day supply. You may receive up to a 90-day supply of a prescribed maintenance medication through our mail-order program. Specialty drugs are limited to a 30-day supply. You must use dispensing amounts as directed unless instructed by your physician otherwise.
- **Why use generic drugs?** Generic medications have the same benefits, ingredients and safety as brand-name medications but without the high dollar cost. With the price of prescription medicine rising, it's nice to find where you can save money without compromising on quality.
- **When you do have to file a claim,** For out of network claims, please contact Humana's customer service for reimbursement.

If there is a national emergency or you are called to active military duty, you may call 1-800-256-3316. A representative will review criteria to determine whether you may obtain more than your normal dispensing amount.

- **A generic equivalent will be dispensed if it is available.** When brand name drugs are purchased and a generic is available, you must pay the difference between the brand name and generic cost plus any applicable brand copay, unless the physician writes "dispense as written" on the prescription. The physician must write "dispense as written" on the prescription for you to receive a brand name drug and only pay the brand name copay, if a generic is available.

You can visit our web site at <https://feds.humana.com/> to check the copayment for your prescription drug coverage before you get your prescription filled. You can also find out more about possible drug alternatives and the locations of participating pharmacies.

Benefit Description	You pay
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a licensed physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetes supplies including testing agents, lancet devices, alcohol swabs, glucose elevating agents, insulin delivery devices and blood glucose monitors approved by us. <ul style="list-style-type: none"> - Disposable needles and syringes for the administration of covered medications • Self administered injectable drugs • Drugs for sexual dysfunction • Drugs or drug therapies for the treatment of gender dysphoria supported by FDA approved prescribing information and/or clinical treatment guidelines • Oral fertility drugs • Growth hormones • Select vitamins only if they include the legend: "Federal law prohibits dispensing without a prescription" • Weight loss drugs <p>Note: Blood Glucose Monitors are also covered under Durable Medical Equipment. (See Section 5(a), page 34.)</p> <p>Note: Drugs to treat sexual dysfunction are limited. Contact the Plan for dosage limits. You pay the applicable drug copay up to the dosage limits, and all charges after that.</p>	<p>\$5 copay for Level One drugs</p> <p>\$15 copay for Level Two drugs</p> <p>\$25 copay for Level Three drugs</p> <p>25% of the amount that the Plan pays to the dispensing pharmacy for Level Four drugs</p> <p>2 applicable copays for a 90-day supply of prescribed maintenance drugs, when ordered through our mail order program, or 2.5 times the applicable copay at participating retail pharmacies</p>
<ul style="list-style-type: none"> • Women's contraceptive drugs and devices, including the "morning after pill" 	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
<p>Covered medications and supplies (cont.)</p> <ul style="list-style-type: none"> Over-the-counter drugs when prescribed by a physician (only applies to proton pump inhibitors, non-sedating antihistamines and ocular allergy agents) Tobacco Cessation drugs <p>Note: The above over-the-counter drugs and devices approved by the FDA require a written prescription by an approved provider. Some restrictions may apply.</p>	<p>High Option</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Drugs available without a prescription, or for which there is a non-prescription equivalent available, except as listed above Drugs and supplies for cosmetic purposes (such as Rogaine) Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except as listed above Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies Drugs to enhance athletic performance Medical supplies such as dressings and antiseptics Non-prescription medications/medicines <p>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefits. (See page 35.)</p>	<p>All charges</p>
<p>Preventive care medications</p>	<p>High Option</p>
<p>The following are covered:</p> <ul style="list-style-type: none"> Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age Folic acid supplements for women of childbearing age: 400 & 800 mcg Prenatal vitamins for pregnant women Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 years Statin Medications for ages 40 years old or older: generic forms of atorvastatin, lovastatin and simvastatin Breast cancer risk reduction medications for women with increased risk for breast cancer Colonoscopy bowel preparation medications for Adults age 50 to 75 Prevention of Human Immunodeficiency virus (HIV) Infection – Pre Exposure Prophylaxis (HIV PreP) Preventive vaccines for children and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) <p>Note: To receive this benefit a prescription from a doctor must be presented to the pharmacy.</p> <p>Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations</p>	<p>Nothing</p>

Preventive care medications - continued on next page

Benefit Description	You pay
<p>Preventive care medications (cont.)</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs available without a prescription, or for which there is a non-prescription equivalent available, except as listed above</i> • <i>Drugs and supplies for cosmetic purposes (such as Rogaine)</i> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except as listed above</i> • <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> <p><i>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefits. (See page 35.)</i></p>	<p>High Option</p> <p><i>All charges</i></p>

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$100 per person (\$300 per Self Plus One enrollment, or \$300 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- If you are enrolled in a Federal Employee Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB plan will be first/primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB plan. See Section 9, *Coordinating benefits with Medicare and other coverage*.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	25% of charges
Dental benefits	High Option
We have no other dental benefits.	<i>All charges</i>

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option: we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefit agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Wellness Reminders	You may receive messages by phone, mail or e-mail on topics such as mammograms, immunizations, and more.
MyHumana (Humana.com)	Once you've taken the Health Assessment, check out MyHumana for resources and information to help improve your overall health. You will also find shop-and-compare tools to help you choose hospitals and doctors, as well as health encyclopedias and practical information about health conditions, prescription drugs, and other health issues. The site also has video and audio health libraries, discounts and coupons for health-related programs.
Humana Pharmacy	Humana Pharmacy, a prescription home delivery service, is a wholly owned subsidiary of Humana that gives members convenience, savings, guidance, and excellent Customer Service. Humana Pharmacy is a fast and easy alternative to retail pharmacies. Depending on your location and benefits, you may be able to use Humana Pharmacy. Call 1-800-379-0092, TTY 711.
HumanaBeginnings[®]	Registered nurses offer education and support to mothers throughout pregnancy and the baby's first months. Call 1-866-488-5992 Ext: 5474.
CalidadHUMANA	Disease management program to help members and families manage chronic medical conditions. Specialists focus on: Asthma, Congestive Heart Failure, Diabetes, Coronary Artery Disease, COPD, Hyperlipidemia, Obesity. Call 1-877-589-2819.
Transplant Coordinator	This specialized team helps transplant recipients coordinate benefits, facilitate services, and follow their treatment plans. Call 1-866-488-5992 Ext: 4213, 5593.
Maximize Your Benefit (MYB)	The Maximize Your Benefit (MYB) program, available to Humana members (through www.humana.com), offers guidance in helping you control the rising cost of prescription drugs with information about generics, lower cost alternatives and prescription home delivery service.
Personal Nurse[®]	Registered nurses support those who are following treatment plans or who need continued guidance in reaching their long-term health goals. Call 1-866-488-5992.

Feature	Description
Services for deaf and hearing impaired	Humana offers telecommunication devices for the deaf (TDD) and Teletype (TTY) telephone lines for the hearing impaired. Call 1-800-218-2560 to access the service.

Section 5(i). Point of Service Benefits

Facts about the Point of Service Plan

At your option, you may choose to obtain benefit coverage for medical services under this Plan using one of three methods:

- Services directed by the primary care physician. These benefits (copayment and coinsurance levels) are listed in Section 5 of this brochure.

You may also access the Plan's Point of Service Benefit Options which are:

- Services not directed by the primary care physician but using Plan providers; or
- Services not directed by the primary care physician using non Plan providers.

When services are rendered by Plan providers, the copayment fees established for certain services will be paid directly to the health service provider.

When services are rendered by non Plan providers, the member will pay for all of the services and request reimbursement from Humana. Reimbursement will be based on the rate contracted by Humana for those services less the corresponding copayment or coinsurance. **The member will also be responsible for satisfying the \$100 for Self Only, or \$300 for Self Plus One or Self and Family annual deductible.**

For out of area non-emergency services that are not coordinated with Humana, a coinsurance of 20% of the allowable fee up to \$2,000 will apply.

What is covered under the Point of Service Option

This is a summary of the benefits that you receive when accessing services that have not been directed by your primary care physician and/or specialist.

- For all physician's office visit services, you pay an \$10 copay per visit. This includes hospital and skilled nursing facility visits.
- For all inpatient admissions, you pay a \$50 copay per admission.
- For home visits by a doctor, and for care received in a skilled nursing facility, you pay a \$25 copay.
- For an ambulatory surgery facility, you pay a \$25 copay.
- For local ambulance service, you pay a \$25 copay (no charge if you are transferred between facilities during a hospitalization in the Plan's service area).
- For professional charges for inpatient and outpatient dialysis services, hospice services, costs for blood and blood plasma, home health services, and rehabilitation therapy, you pay 25% of the charges.
- For allergy testing and injections, durable medical equipment, orthopedic devices, prosthetic devices, you pay 50% of the charges.
- For air ambulance charges, you pay a \$50 copay.
- For routine outpatient laboratory, X-ray, and diagnostic tests you pay nothing when using plan providers; you pay 25% of covered services when using a non-plan provider.
- For pathology and radiology services provided to hospitalized members you pay nothing when using plan providers; you pay 25% of covered services when using non-plan providers.
- For organ and tissue transplants you pay 25% of covered services when using only plan providers. All services must be determined and authorized through our transplant department, utilizing our National Transplant Network.
- For emergency services you pay a \$25 copay for services received at an urgent care center and a \$50 copay per visit for services received as an outpatient at a hospital.
- Mental health services are treated the same as any other illness.

What is not covered

- Prescription drugs obtained at non-plan pharmacies (for out of area emergencies – submit itemized receipts to us for payment).
- Organ/tissue transplants performed at non-plan facilities.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact us at, 1-800-314-3121 option 1 and then option 2 or visit our website at www.humana.com.

Dental benefits

The following services will be covered when medically necessary:

Diagnostic and preventive: You pay nothing for: Initial oral examination, one per policy year; Periodic oral examination, every six (6) months; Emergency oral examination, every six (6) months; Complete series of radiographs (FMX), one set every three (3) years; Intraoral periapical X-rays, one initial and five additional, per policy year; Bitewings, one or two films; every two (2) years; Panoramic film, one every three (3) years; Adult (over 14 years) prophylaxis, every six (6) months; Adult (over 14 years) prophylaxis, every six (6) months; Children (under 14 years) prophylaxis, every six (6) months; Topical application of fluoride for children (under 19 years), limited to one (1); Sealant per tooth, per insured tooth per lifetime; Space maintainer, one per area per insured per lifetime; Professional consultation, every six (6) months.

Restorative Services: You pay 25% coinsurance in-network for: Amalgam restorations and/or resin restorations; Bicuspid and molars; Retrograde filling; Apicoectomy; Root amputation; Anesthesia; Surgical extractions of erupted tooth and residual root; Palliative treatment (unclassified treatment); Stainless steel crowns in primary teeth; Exostosis; Frenulectomy (frenectomy).

Prosthesis Services: You pay 50% (\$800 annual maximum) for: Crowns; Partial and complete dentures; including repair and adjustments; Maryland bridge; Fixed bridge.

Periodontic: You pay 50% (\$800 annual maximum) for: Periodontics exams; Gingivectomy and gingivoplasty; Root planning; Gum diseases and the bone which holds the teeth.

Orthodontics: You pay 50% (\$1,000 per year) for: Braces and treatment, up to a maximum of \$600; Monthly visits, up to a maximum of \$100; Retainers, up to a maximum of \$300.

EyeMed Vision Program

EyeMed Vision Program (VIS 453): This plan provides coverage for one vision exam and one pair of eyeglasses or contact lenses every 12 months for each covered member. In addition to the plan benefits, Humana members also receive discounts for many vision services and materials. Some of these discounts and discounted fees are outlined below. Additional information can be obtained through www.humana.com. For a complete participating optical provider listing, call 1-888-289-0595 or visit www.humana.com.

EyeMed Vision Discount Program: Discounts available at participating providers for: Eye exams, frames and lenses, contact lenses, and lasik.

See separate plan description for benefits. See our web site for participating providers, or call 1-866-995-9316 for the EyeMed provider locator service. No additional premium required. **(Please note: Discounts are a feature of Humana membership, and not considered as insurance.)**

Contact us for additional information concerning specific benefits, exclusions, limitations, eligible providers and other provisions of each of the above coverages.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *You need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (See specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies we are prohibited from covering under the Federal Law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-800-314-3121, option 1 and then option 2 or at our website <https://feds.humana.com>.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: Humana Puerto Rico
Attn: Claims review
P.O. Box 191920
San Juan, Puerto Rico 00919-1920

Prescription drugs and other supplies or services

Submit your claims to: Humana Puerto Rico at the address listed above or call us at 1-800-314-3121, option 1 and then option 2.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Humana Puerto Rico, P.O. Box 191920, San Juan, Puerto Rico 00919-1920 or calling 1-800-314-3121, option 1 and then option 2.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: Humana Puerto Rico, P.O. Box 191920, San Juan, Puerto Rico 00919-1920; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.</p>

Step	Description
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.</p>
3	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
4	<p>OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.</p> <p>If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.</p>

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-800-523-0023. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 1-(202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage or coverage for injuries

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called “double coverage”.

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at <https://feds.humana.com/>. That insurance coverage is the primary payor and we are the secondary payor.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

• TRICARE and CHAMPVA

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

• Workers’ Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers’ Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

• Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

By accepting benefits under this plan you agree to the following conditions and limitations on the nature of benefits or benefit payments when another person causes an injury or illness or when you are entitled to recover from any other insurance or source of funds that may be available to pay for the injury or illness.

Humana is entitled to recover the full value of the benefits we have paid or provided in connection with your injury or illness. However, when benefits are otherwise provided by this plan we will cover the cost of treatment that exceeds the amount of the payment you received. You and all covered persons agree to promptly notify us that you have asked anyone other than us to make payment for your injuries and to fully cooperate with our efforts to secure our recovery rights. You and your representative also agree to obtain our consent before releasing any party from liability for payment of medical expenses and before disbursing any funds paid by other parties.

When benefits are provided under the Plan in relation to the illness or injury, Humana may, at its option:

- Subrogate, that is, take over your right to pursue recovery from any other parties, insurance carriers or sources of funds that you may have a right to pursue; or
- Enforce a right to reimbursement from any payment(s) you or your representative may obtain from other parties, settlements or insurance coverage.

Our right to recover the full value of the benefits we have paid or provided for shall take first priority (before any of the rights of any other parties are honored) and are not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. The amount we are entitled to recovery is not subject to reduction based on attorney fees or costs under the “common fund” or similar rules and is fully enforceable regardless of whether you are “made whole” or compensated for the full amount of damages you may have incurred.

Our recovery rights shall apply only to the extent of the full value of benefits provided for the injury or illness. We will provide benefits to cover the cost of treatment that exceeds amounts that are recoverable other insurance coverage or sources of funds.

If you, a covered person or your representative fails to cooperate with the enforcement of our recovery rights we may delay or deny future benefits until cooperation is provided or we are reimbursed.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.com or by phone at 1-877-888-3337, TTY 1-877-889-5680, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient’s condition, whether the patient is in a clinical trial or is receiving standard therapy.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on “What is Medicare?” and “Should I Enroll in Medicare?” please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

• **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-314-3121 option 1 and then option 2.

We waive some costs if the original Medicare Plan is your primary payor. We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other healthcare professionals.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part A and B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible

High Option You Pay Without Medicare: \$0
High Option You Pay With Medicare Part A & B: \$0

Benefit Description: Out-of-Pocket Maximum

High Option You Pay Without Medicare: \$4,000 Self Only/\$8,000 Self Plus One or Self and Family
High Option You Pay With Medicare Part A & B: \$4,000 Self Only/\$8,000 Self Plus One or Self and Family

Benefit Description: Part B Premium Reimbursement

High Option You Pay Without Medicare: NA
High Option You Pay With Medicare Part A & B: NA

Benefit Description: Primary Care Physician

High Option You Pay Without Medicare: \$5 per office visit
High Option You Pay With Medicare Part A & B: \$0

Benefit Description: Specialist

High Option You Pay Without Medicare: \$5 per office visit
High Option You Pay With Medicare Part A & B: \$0

Benefit Description: Inpatient Hospital

High Option You Pay Without Medicare: \$0
High Option You Pay With Medicare Part A & B: \$0

Benefit Description: Outpatient Hospital

High Option You Pay Without Medicare: \$25 per surgery
High Option You Pay With Medicare Part A & B: \$0

Benefit Description: Incentives Offered

High Option You Pay Without Medicare: N/A
High Option You Pay With Medicare Part A & B: N/A

You can find more information about how our plan coordinates benefits with Medicare by calling 1-800-4HUMANA or visit the Medicare website at <https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance>.

• **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

• **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary. We will not waive any of the copayments, coinsurance or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare. For information about Medicare Advantage plans offered in your area call 1-866-836-5079.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payor for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	<p>An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.</p> <ul style="list-style-type: none">• Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy• Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.• Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	See Section 4, page 22.
Copayment	See Section 4, page 22.
Cost-sharing	See Section 4, page 22.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services provided to you such as assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed, and maintaining continence, which are not likely to improve your condition. Custodial care that lasts 90 days or more is sometimes known as long term care.
Deductible	See Section 4, page 22.
Experimental or investigational services	<p>A drug, biological product, device, medical treatment, or procedure is determined to be experimental or investigational if reliable evidence shows it meets one of the following criteria:</p> <ul style="list-style-type: none">• when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials, or• when applied to the circumstances of a particular patient is under study with written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or• is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by the USFDA or Department of Health and Human Services, or• is not generally accepted by the medical community. <p>Reliable evidence means, but is not limited to, published reports and articles in authoritative medical scientific literature or regulations and other official actions and publications issued by the USFDA or the Department of Health and Human Services.</p>
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	The determination as to whether a medical service is required to treat a condition, illness, or injury. In order to meet the standard of medical necessity the service must be consistent with symptoms, diagnosis, or treatment; consistent with good medical practice; and the most appropriate level of service that can be safely provided.

Plan allowance	<p>Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance using Humana's fee schedule for similar providers in Puerto Rico.</p> <p>You should also see <i>Important Notice About Surprise Billing – Know Your Rights</i> in Section 4 that describes your protections against surprise billing under the No Surprises Act.</p>
Post-service claims	<p>Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.</p>
Pre-service claims	<p>Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.</p>
Reimbursement	<p>A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.</p>
Subrogation	<p>A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.</p>
Urgent care claims	<p>A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:</p> <ul style="list-style-type: none"> • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. <p>Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.</p> <p>If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-4HUMANA. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.</p>
Us/We	<p>Us and We refer to Humana Health Plans of Puerto Rico, Inc.</p>
You	<p>You refers to the enrollee and each covered family member.</p>

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Notes

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Summary of Benefits for the High Option of Humana Health Plans of Puerto Rico, Inc.- 2022

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at <https://feds.humana.com/>.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Below, an asterisk (*) means the item is subject to the \$100 calendar year deductible.

Benefits	You pay	Page
Medical services provided by physicians:		
• *Diagnostic and treatment services provided in the office	\$5 copay per office visit	27
Services provided by a hospital: Inpatient	Nothing	42
Services provided by a hospital: Outpatient surgery	\$25 copay	43
Services provided by a hospital: Outpatient, other services	Nothing	43
Emergency benefits (In area and out-of-area):	\$5 copay per office visit; \$25 copay per visit to an urgent care center or \$50 hospital copay	46
Mental health and substance use disorder treatment:	Regular cost-sharing	47
Prescription drugs Rx4: Level One drugs	\$5 copay	50
Prescription drugs Rx4: Level Two drugs	\$15 copay	50
Prescription drugs Rx4: Level Three drugs	\$25 copay	50
Prescription drugs Rx4: Level Four drugs	25% coinsurance	50
Prescription drugs Rx4: Maintenance drugs (90-day supply) when ordered through our mail-order program	2 applicable copays	50
Dental care: Accidental injury benefit only	25% of allowance	53
Vision care: Eye exam	\$5 copay per office visit	32
Special features: Personal Nurse; MyHumana; Humana <i>Beginnings</i> ; CalididHUMANA; Transplant coordinator; TDD and TTY phone lines	see section 5(h)	54
Point of Service benefits:	See section 5(i)	57
Protection against catastrophic medical and pharmacy costs (out-of-pocket maximum).	Participating: Nothing after \$4,000 for Self Only, or \$8,000 for Self Plus One or Self and Family. Non-Participating: Nothing after \$4,000 for Self Only, or \$8,000 for Self Plus One or Self and Family.	22

2022 Rate Information for Humana Health Plans of Puerto Rico, Inc.

To compare your FEHB health plan options please go to www.opm.gov/fehcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

Puerto Rico

High Option Self Only	ZJ1	\$166.42	\$55.47	\$360.57	\$120.19
High Option Self Plus One	ZJ3	\$357.80	\$119.27	\$775.24	\$258.41
High Option Self and Family	ZJ2	\$374.45	\$124.81	\$811.30	\$270.43