# NPOS Copay Plan $2,000/$4,000

Includes personal care account
Summary of Benefits

| Jan. 1–Dec. 31, 2022 Plan year | Plan pays for services at National POS-Open Access Plus providers | Plan pays for services at out-of-network providers |
|---|---|---|
| **Annual deductible** (amount paid by member per plan year) | | |
| Individual | $2,000 | $6,000 |
| Family | $4,000 | $12,000 |
| **Coinsurance** (amount paid by the plan after deductible) | | |
| | 70% | 50% |
| **Maximum out-of-pocket (MOOP) limits** (amount paid by member, including deductible, copays and coinsurance per plan year for medical and pharmacy expenses combined)[1] | | |
| Individual | $7,900 | $23,700 |
| Family | $15,800 | $47,400 |
| **Lifetime maximum benefit** | | |
| | Unlimited | Unlimited |
| **Preventive services** (Routine expenses are those not incurred as a result of a diagnosis of a specific bodily injury or sickness.) | | |
| Routine child care (to age 18) | 100% | 50% after deductible |
| Routine adult physical exam (18 years and above) | 100% | 50% after deductible |
| Routine immunizations | 100% | 50% after deductible |
| Routine Pap smear/mammogram | 100% | 50% after deductible |
| Routine lab test/X-rays associated with routine physical exam | 100% | 50% after deductible |
| Routine endoscopic services (including colonoscopy) | 100% | 50% after deductible |
| Oral contraceptives and contraceptive supplies and devices[2] | 100% | 50% after deductible |
| Breastfeeding supplies and devices[3] | 100% | 50% after deductible |
| Lung cancer screening | 100% | 50% after deductible |

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|---|---|---|
| **Physician services** | | |
| Office visits (including tests, lab/X-rays; excluding advanced imaging) | | |
| • Primary care physician | 100% after $35 copay | 50% after deductible |
| • Specialist | 100% after $60 copay | 50% after deductible |
| Allergy injections | 100% after $5 copay per injection | 50% after deductible |
| Allergy testing and serum | 70% after deductible | 50% after deductible |
| Emergency room physician services (in-network benefits paid if medical emergency) | 70% after deductible | 50% after deductible |
| Inpatient | 70% after deductible | 50% after deductible |
| Surgery performed in the physician's office | 70% after deductible | 50% after deductible |
| Advanced imaging (PET, MRI, MRA, CAT, SPECT)[4] | 100% after $300 copay | 50% after deductible |
| **Hospital services** | | |
| Inpatient care[4] | 70% after deductible | 50% after deductible |
| Outpatient surgery – facility | 70% after deductible | 50% after deductible |
| Ambulatory surgical center – outpatient surgery | 70% after deductible | 50% after deductible |
| Outpatient endoscopic services | 70% after deductible | 50% after deductible |
| Outpatient nonsurgical (including tests, lab/X-rays) | 70% after deductible | 50% after deductible |
| Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)[4] | 100% after $300 copay | 50% after deductible |
| Hospital emergency services (in-network benefits paid if medical emergency) | 100% after $350 copay | 100% after $350 copay |
| Urgent care center | 100% after $75 copay | 50% after deductible |
| **Mental health/substance abuse services** | | |
| Inpatient services[4] | 70% after deductible | 50% after deductible |
| Inpatient professional services[4] | 70% after deductible | 50% after deductible |
| Outpatient therapy session | 100% after $35 copay | 50% after deductible |
| Outpatient services at a residential treatment facility | 100% after $35 copay | 50% after deductible |

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|---|---|---|
| **Additional medical services** | | |
| Physical (PT), speech (ST), occupational (OT), hearing, cognitive therapy (60 total visits per plan year for all modalities combined)[4,5] | 100% after $60 copay | 50% after deductible |
| Chiropractic (30 visits per plan year)[5] | 100% after $60 copay | 50% after deductible |
| Home health care (100 visits per plan year)[4,5] | 70% after deductible | 50% after deductible |
| Durable medical equipment[4] | 70% after deductible | 50% after deductible |
| Skilled nursing facility (60 days per plan year)[4,5] | 70% after deductible | 50% after deductible |
| Ambulance (in-network benefits paid if medical emergency) | 70% after deductible | 50% after deductible |
| Transplant services[4,6] | 70% after deductible | 50% after deductible |
| Fertility counseling and treatment (up to $10,000 lifetime limit)[7] | 70% after deductible | 50% after deductible |
| Morbid obesity treatment (including limited covered surgical procedures) (up to $10,000 lifetime limit)[4,7] | 70% after deductible | 50% after deductible |
| Hearing aids (covered up to $1,400 per ear every 3 plan years) | 70% after deductible | 50% after deductible |
| Acupuncture (up to 12 visits per plan year)[5,8] | 70% after deductible | 70% after in-network deductible |
| Nutrition/dietitian counseling for:<br>• Diabetes and obesity<br>• Eating disorders, cancer, celiac disease, rheumatoid arthritis and inflammatory bowel disease | 100%<br>100% after office visit copay | 50% after deductible<br>50% after deductible |

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| **Hospice services**[4] | | |
| Inpatient/outpatient | 70% after deductible | 50% after deductible |
| **Prescription drugs** (amount paid by member) | | |
| Preventive Rx medicines[9] | No cost when filled at a Humana-owned pharmacy (when filled at any other in-network pharmacy, subject to Rx4 cost share) | 50% and copay[1, 11] |
| Tobacco-cessation medicines (including over the counter medicines when prescribed by a physician) | No cost | 50% and copay[1, 11] |
| Other medicines (Rx4)[10] | | |
| • Level 1 | $10 copay | 50% and copay[1, 11] |
| • Level 2 | $40 copay | 50% and copay[1, 11] |
| • Level 3 | $70 copay | 50% and copay[1, 11] |
| • Level 4 | 25% coinsurance | 50% and coinsurance[1, 11] |

## Payments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[11]Member is also responsible for 100% of charges over the default rate.

# Important!

## At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

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

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
**فارسی (Farsi)**
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę nika'adoowoł.
**العربية (Arabic)**
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك