

## HUMANA HEALTH PLAN, INC.: KY LG CF

### Maximum Out-of-Pocket Explanation

Coverage Period: 01/01/2016 - 12/31/2016

Plan Type: CF Copay

### Special Notice:

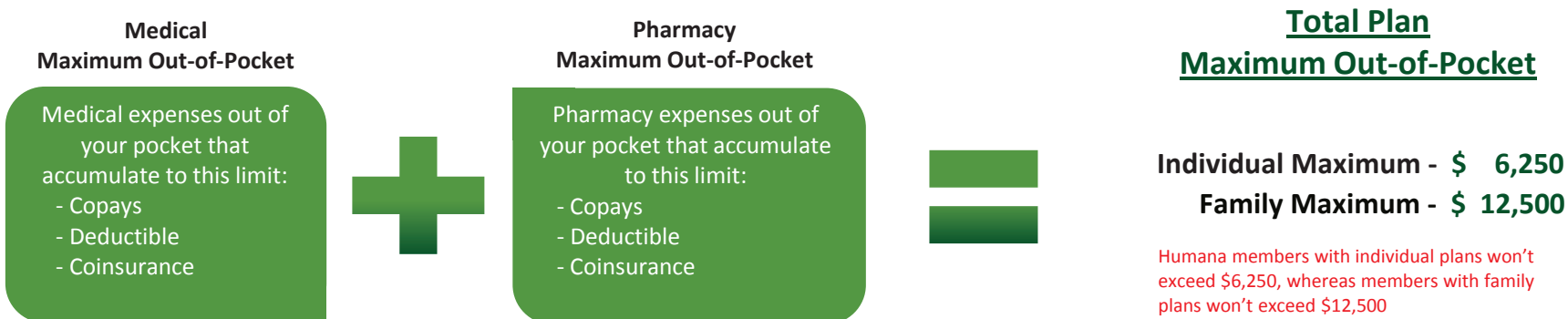
Starting in 2014 there will be a federally mandated maximum out-of-pocket (MOOP) limit that health insurance plans cannot exceed. All health insurance plans with non-grandfathered status, both fully insured and self-funded must have the MOOP include all member cost sharing for medical and pharmacy (excluding premiums, balance billing amounts for non-network providers, or spending for non-covered services). Cost-sharing includes all copayments, deductibles, and coinsurance amounts for medical, behavioral health and pharmacy amounts. The inclusion of copayments in the MOOP will likely be a change to your plan.

Beginning 1.1.14 your in-network medical and pharmacy out-of-pocket maximums combine and cannot exceed the total plan maximum out-of-pocket.

Below illustrates your plan's maximum out-of-pocket limits for in-network services:

Individual Medical Maximum Out-of-Pocket: \$ 4,500  
Individual Pharmacy Maximum Out-of-Pocket: \$ 2,500

Family Medical Maximum Out-of-Pocket: \$ 9,000  
Family Pharmacy Maximum Out-of-Pocket: \$ 5,000



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**HUMANA HEALTH PLAN, INC./HUMANA INSURANCE**  
**COMPANY: NEW ALBANY FLOYD COUNTY SCHOOLS NPOS**

Coverage Period: Beginning on or after 01/01/2016  
 Coverage For: Individual + Family | Plan Type: NPOS

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.humana.com](http://www.humana.com) or by calling 1-866-4ASSIST (427-7478).

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	Network: <b>\$1,500 Individual / \$3,000 Family</b>  Non-Network: <b>\$4,500 Individual / \$9,000 Family</b>  Doesn't apply to prescription drugs and preventive services. Co-insurance and co-payments don't count toward the deductible <b>\$500</b> Network benefit allowance applies before deductible. Does not apply to any member copayments, Rx, or preventive care.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses</b>	Yes. For Network providers <b>\$4,500 Individual / \$9,000 Family</b>  For Non-Network providers <b>\$13,500 Individual / \$27,000 Family</b>	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, Balance-billed charges, Health care this plan doesn't cover, Penalties, Non-network transplant, Out-of-network Co-Insurance, prescription drugs, specialty drugs	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.

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**Questions:** Call 1-866-4ASSIST (427-7478) or visit us at [www.humana.com](http://www.humana.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-4ASSIST (427-7478) to request a copy.

<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://www.humana.com">www.humana.com</a> or call 1-866-4ASSIST (427-7478) for a list of Network providers.	If you use a network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network <b>provider</b> for some services. Plans use the term network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 copay/visit	50% coinsurance	—————none—————
	Specialist visit	\$50 copay/visit	50% coinsurance	—————none—————
	Other practitioner office visit	Chiropractor Exam: \$50 copay/visit	Chiropractor Exam: 50% coinsurance	Chiropractor: 25 visits per calendar year
	Preventive care / screening / immunization	No charge	50% coinsurance	limited coverage for preventive care
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No charge after deductible	50% coinsurance	Cost share may vary based on where service is performed
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Cost share may vary based on where service is performed

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  <b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.humana.com">www.humana.com</a>.</b>	Level 1 - Lowest cost generic and brand-name drugs	\$15 copay (Retail) \$30 copay (Mail Order)	30% coinsurance (Retail) Not Covered (Mail Order)	30 day supply (Retail) 90 day supply (Mail Order)
	Level 2 - Higher cost generic and brand-name drugs	\$35 copay (Retail) \$70 copay (Mail Order)	See Level 1 for Non-Network benefit	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	\$55 copay (Retail) \$110 copay (Mail Order)	See Level 1 for Non-Network benefit	
	Level 4 - Highest cost drugs	25% coinsurance (Retail) 25% coinsurance (Mail Order)	See Level 1 for Non-Network benefit	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	
	Physician/surgeon fees	\$30/\$50 copay/visit	50% coinsurance	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	\$200 copay/visit	\$200 copay/visit	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	—————none—————
	Urgent care	\$75 copay/visit	50% coinsurance	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$200 copay/day	50% coinsurance	1 for 3 days
	Physician/surgeon fee	20% coinsurance	50% coinsurance	—————none—————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copay	50% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	\$200 copay/day	50% coinsurance	1 for 3 days Preauthorization required, penalty may apply
	Substance use disorder outpatient services	\$30 copay	50% coinsurance	—————none—————
	Substance use disorder inpatient services	\$200 copay/day	50% coinsurance	1 for 3 days Preauthorization required, penalty may apply
<b>If you are pregnant</b>	Prenatal and postnatal care			—————none—————
	Delivery and all inpatient services	\$200 copay/day	50% coinsurance	1 for 3 days
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	50% coinsurance	60 visits per calendar
	Rehabilitation services	Rehabilitation: \$50 copay/visit Therapy: \$45 copay/visit	Rehabilitation: 50% coinsurance Therapy: 50% coinsurance	60 visits per calendar year Any limits for Habilitation services and Rehabilitation services are combined.
	Habilitation services	Habilitation: \$50 copay/visit Therapy: \$50 copay/visit	Habilitation: 50% coinsurance Therapy: 50% coinsurance	60 visits per calendar year Any limits for Habilitation services and Rehabilitation services are combined.
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days per calendar year
	Durable medical equipment	20% coinsurance	50% coinsurance	
	Hospice service			
<b>If your child needs dental or eye care</b>	Eye exam	No charge	Not Covered	—————none—————
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	—————none—————

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, unless for a congenital anomaly, injury, infection, disease
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Hearing Aids
- Infertility treatment
- Long-term care
- Non Emergent Care when traveling outside the U.S. more than 6 consecutive months in a year
- Routine foot care
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care - spinal manipulations are covered

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Humana, Inc.: [www.humana.com](http://www.humana.com) or 1-866-4ASSIST (427-7478)

Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, IN 46204-2787, Phone: 317-232-2427

Additionally, a consumer assistance program can help you file your appeal. Contact the Department of Insurance, Consumer Services Division, 311 West Washington Street, Suite 300, Indianapolis, IN 46204-2787, Phone: 317-232-2395 or 800-622-4461, Fax: 317-234-2103

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does not provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This plan or policy does provide minimum essential coverage.**

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

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,640
- Patient pays \$1,900

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,000
Copays	\$500
Coinsurance	\$400
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,900</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,680
- Patient pays \$1,720

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$1,700
Coinsurance	\$0
Limits or exclusions	\$20
<b>Total</b>	<b>\$1,720</b>



# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from network **providers**. If the patient had received care from non-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

\***No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

\***No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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