Humana National POS

New Albany Floyd County Consolidated School Corp

Indiana

The Purpose of This Benefit Summary
A benefit summary provides a brief overview of basic health plan features. For exact terms and conditions of your health plan benefits, please refer to your Benefit Plan Document, also known as your Certificate.

90/60 COPAYMENT PLAN 11	IF YOU USE IN-NETWORK PROVIDERS		IF YOU USE OUT-OF-NETWORK PROVIDERS	
Annual Deductible (The annual deductible is based upon a calendar year. Deductible and out-of-pocket limits for in-network and out-of-network providers calculate separately.)	Individual $500	Family (1) $1,000	Individual $1,500	Family (1) $3,000
Medical Out-of-Pocket Expense Limit (Maximum Out-of-Pocket Expense Limit includes copayments and deductibles.)	Individual $2,500	Family $5,000	Individual $7,500	Family $15,000
Preventive Care				
• Preventive office visits (up to age 18) • Preventive immunizations (up to age 18) • Preventive office visits (18 years and above) • Preventive mammography • Preventive Pap Smears • Preventive outpatient laboratory tests • Preventive endoscopy • Preventive prostate screenings • Preventive flu/pneumonia immunization	100%		60% after deductible	
Physician Services (2)				
• Office visits (excludes diagnostic lab and X-ray)	100% after $20 primary care physician/ $40 specialist copayment per visit		60% after deductible	
• Allergy testing (covered as part of office visit) • Diagnostic tests, lab and X-rays (when performed in an office or clinic) • Allergy serum	100%		60% after deductible	

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90/60 COPAYMENT PLAN 11	IF YOU USE IN-NETWORK PROVIDERS	IF YOU USE OUT-OF-NETWORK PROVIDERS
Physician Services (2) (continued)		
• Physician visit to emergency room (4)	100%	100%
• Inpatient/outpatient services • Physician surgery	90% after deductible	60% after deductible
• Allergy injections	100% after $5 copayment	60% after deductible
Facility Services		
• Inpatient care (semiprivate room and board, nursing care, ICU) • Outpatient surgery • Outpatient nonsurgical care	90% after deductible	60% after deductible
• Emergency room visit (copayment is waived if admitted) (4)	100% after $200 copayment per visit	100% after $200 copayment per visit
Prescription Drugs		
• Retail • Rx Maximum out-of-pocket includes Rx copayments $2,500	100% after Level One $15 copayment Level Two $35 copayment Level Three $55 copayment Level Four 25% to $150 maximum	60% after deductible
• Mail Order	Two times copayment	NA
Other Medical Services (3)		
• Skilled nursing facility (up to 60 days per calendar year) • Home health care (up to 60 visits per calendar year) • Durable medical equipment • Advanced imaging (PET, MRI, MRA, CAT, SPECT)	90% after deductible	60% after deductible
• Physical, occupational, cognitive, speech and audiology therapy, spinal manipulations, adjustments, and modalities (up to 60 visits per calendar year) Out-of-network is limited to 10 of the 60 visits.	Same as specialist office visit	60% after deductible
• Advanced imaging in emergency room (PET, MRI, MRA, CAT, SPECT) • Ambulance (4)	90% after deductible	90% after in-network deductible
• Urgent Care	100% after $75 copayment per visit	60% after deductible
• Retail clinics	Same as primary care office visit	60% after deductible
• Maternity	Same as any other condition	Same as any other condition
Mental Health		
• Inpatient services	90% after deductible	60% after deductible
• Outpatient services	Same as specialist office visit	60% after deductible
Alcohol and Chemical Dependency		
• Inpatient services	90% after deductible	60% after deductible
• Outpatient services	Same as specialist office visit	60% after deductible