National POS CoverageFirst®

New Albany Floyd County Consolidated School Corp

Indiana

COVERAGEFIRST COPAYMENT 80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS		PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS	
Up-front Benefit Allowance				
• Annual member benefit (Applies to medical services received from participating providers only. Does not apply to member copayments.)	$500 per calendar year per member		Not applicable	
Annual Deductible (per plan year; copayments do not apply)	Individual $1,500	Family $3,000	Individual $4,500	Family $9,000
Medical Out-Of-Pocket Expense Limit (includes deductibles and copayments)	Individual $4,500	Family $9,000	Individual $13,500	Family $27,000
Preventive Care (Does not reduce the benefit allowance)				
• Annual routine adult physical exam (18 years and above) • Routine child care (up to age 18) • Routine immunizations (up to age 18) • Routine mammography and Pap smears • Routine outpatient laboratory tests/X-rays • Preventive endoscopy (includes colonoscopy, proctosignoidoscopy and sigmoidosocopy	100%		50% after deductible	
Physician Services				
• Office visits (excludes diagnostic lab and X-ray) • Prenatal benefit (office visit copayment applies to first visit only) • Allergy testing (covered as part of office visit)	100% after $30 primary care physician/ $50 specialist copayment per visit		50% after deductible	
• Physician visits to emergency room (3)	100%		100%	
• Diagnostic tests, lab and X-rays (when performed in office or clinic) • Allergy serum	100%		50% after deductible	
• Inpatient services • Outpatient services	80% after deductible		50% after deductible	
• Allergy injections and nonroutine injections other than allergy	100% after $5 copayment per visit		50% after deductible	

Humana.com

COVERAGEFIRST COPAYMENT 80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Hospital Services		
• Inpatient care (semiprivate room and board, nursing care, ICU)	100% after $200 copayment per day for first three days	50% after deductible
• Outpatient surgery – surgery center	100% after $300 copayment per visit	50% after deductible
• Outpatient nonsurgical care • Outpatient surgery – hospital	80% after deductible	50% after deductible
• Emergency room visit (copayment is waived if admitted) (3)	100% after $200 copayment per visit	100% after $200 copayment per visit
• Urgent care facility	100% after $75 copayment per visit	50% after deductible
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		
• Skilled nursing facility (up to 60 days per calendar year) • Home health care (up to 60 visits per calendar year) • Durable medical equipment	80% after deductible	50% after deductible
• Physical, occupational, cognitive, speech and hearing therapy (subject to combined limit for all therapy services up to 60 visits per calendar year)	100% after $50 copayment per visit	50% after deductible
• Ambulance (3)	80% after deductible	80% after deductible
• Chiropractic (subject to 25 visits per calendar year) (out-of-network is limited to 10 of the 25 visits)	Same as specialist copayment	50% after deductible
• Transplant services	80% after deductible (when services are received from a Humana Transplant Network Provider)	50% after deductible (covered expenses are limited to a maximum benefit of $35,000 per transplant)
Behavioral Health (mental health and substance abuse services)		
• Inpatient services • Inpatient professional services • Outpatient therapy sessions	Same as any other covered condition	Same as any other covered condition
Lifetime Maximum Benefit	Unlimited (participating and nonparticipating combined)	