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)	

Prior authorization
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 for payment under your benefit plan. You and your health care 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 Service.

Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

Payments
Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Certificate of Insurance.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

To be covered, expenses must be medically necessary and specified as covered. Please see your Certificate for more information on medical necessity and other specific plan benefits.

(1) You are not required to meet individual deductibles once the family deductible has been met.
(2) Copayments for visits to primary care physicians, as defined in the plan, are generally lower than for visits to specialists. The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician or internist.
(3) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.

Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. Limitations and exclusions to coverage apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing any procedure, treatment or supply. This guide is available at Humana.com/members/enrollment center/pre-enrollment disclosures or through your sales representative.

The amount of benefit provided depends upon the plan selected. Premiums will vary according to the selection made.

For general questions about the plan, contact your benefits administrator.

Offered by Humana Health Plan, Inc. and insured by Humana Insurance Company

Humana.com