

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)
- Allergy testing (covered as part of office visit)
- Diagnostic tests, lab and X-rays (when performed in an office or clinic)
- Allergy serum

100% after \$20 primary care physician/
\$40 specialist copayment per visit

100%

60% after deductible

60% after deductible

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	90% after deductible	60% after deductible
• Physician surgery		
• Allergy injections	100% after \$5 copayment	60% after deductible

Facility Services

• Inpatient care (semiprivate room and board, nursing care, ICU)	90% after deductible	60% after deductible
• Outpatient surgery		
• Outpatient nonsurgical care		
• Emergency room visit (copayment is waived if admitted) (4)	100% after \$200 copayment per visit	100% after \$200 copayment per visit

Prescription Drugs

• Retail	100% after	60% after deductible
• Rx Maximum out-of-pocket includes Rx copayments \$2,500	Level One \$15 copayment Level Two \$35 copayment Level Three \$55 copayment Level Four 25% to \$150 maximum	
• Mail Order	Two times copayment	NA

Other Medical Services (3)

• Skilled nursing facility (up to 60 days per calendar year)	90% after deductible	60% after deductible
• Home health care (up to 60 visits per calendar year)		
• Durable medical equipment		
• Advanced imaging (PET, MRI, MRA, CAT, SPECT)		
• 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)	90% after deductible	90% after in-network deductible
• Ambulance (4)		
• 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

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](https://www.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.

Provider Disclaimer

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.

Primary care physicians are defined as family practitioner, general practitioner, pediatrician or internist.

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

Additional Coverage Information

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](https://www.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

- (1) You are not required to meet individual deductibles once the family deductible has been met.
- (2) The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician, internist and chiropractor.
- (3) Visit and day limits are combined for participating and nonparticipating providers.
- (4) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.

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



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