R-709-2013
C 306-2013

[redacted]

NCD completed by: Ethan Moseley	Date: 12.10.13
Sales Account Representative: Reno Altschul	
Account Implementation Representative: Ethan Moseley	

[redacted]

This Agreement is made and entered into by Lexington Fayette Urban County Government (the "Client") and Humana Insurance Company ("Humana") effective 01/01/2014 with respect to the LFUCG Healthcare Plan ("Plan").
The Client and Humana agree as follows:

(a) The **New Case Document** will be used by Humana to draft the Summary Plan Description and Summary of Benefits and Coverage Document, if applicable, for the Plan and to administer benefits under the Plan during the period prior to the delivery of a final Summary Plan Description and Summary of Benefits and Coverage Document, if applicable. Lack of sign-off and finalization of the SPD(s) may impact benefit quoting and the internal claim appeals and external review process. This includes possible delays in sending out appeals/reviews, which may cause timelines set forth in federal regulations to be missed.

(b) The Client will provide written notice to Humana of any change to the New Case Document, at least 30 days prior to the effective date of the change.

(c) If any changes to the **New Case Document** are necessary, Humana will document the changes in a revised New Case Document as well as an amended Summary Plan Description and Summary of Benefits and Coverage Document, if applicable.

(d) If any changes to the New Case Document require Humana to reprocess claims or change the build, Humana may charge an additional administrative fee. Humana will obtain Client's consent prior to commencing with the reprocessing of claims or changing the build.

(e) If the Client has not executed and returned this Agreement to Humana within 14 days of receipt, or communicated its revisions, the Client is hereby deemed to accept the Agreement and New Case Document in the form attached.

The Client and Humana have caused this agreement to be executed by their respective officers or representatives as duly authorized.

Lexington Fayette Urban County Government

By: _____

Date: 1-7-13

HUMANA INSURANCE COMPANY

By: _____

Khalid Nazir
Vice President

LFUCG HSA1

Kentucky

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 Summary Plan Description.

	IF YOU USE IN-NETWORK PROVIDERS		IF YOU USE OUT-OF-NETWORK PROVIDERS	
Embedded Annual Deductible (5) (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 $2,500	Family (4) $5,000	Individual $7,500	Family (4) $15,000
Embedded Maximum Out-of-Pocket Expense Limit (5) (The Maximum Out-of-Pocket Expense Limit is calculated on a calendar year basis, and does include deductibles.)	Individual $2,500	Family $5,000	Individual $9,000	Family $18,000
Preventive Care				
• Preventive office visits (up to age 18) • Preventive immunizations (up to age 18) • Preventive office visit (18 years and above) • Preventive mammography • Preventive Pap Smears • Preventive outpatient laboratory tests • Preventive endoscopy • Preventive prostate screenings • Preventive flu/pneumonia immunization	100%		70% after deductible	
Physician Services (1)				
• 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 • Inpatient/outpatient services • Allergy injections • Physician surgery	100% after deductible		70% after deductible	
• Physician visit to emergency room (3)	100% after deductible		100% after in-network deductible	

	IF YOU USE IN-NETWORK PROVIDERS	IF YOU USE OUT-OF-NETWORK PROVIDERS
Facility Services		
• Inpatient care (semiprivate room and board, nursing care, ICU) • Outpatient surgery • Outpatient nonsurgical care	100% after deductible	70% after deductible
• Emergency room visit (copayment is waived if admitted) (3)	100% after deductible	100% after in-network deductible
Prescription Drugs	100% after deductible	70% after deductible
Other Medical Services (2)		
• Skilled nursing facility (up to 60 days per calendar year) • Home health care (up to 100 visits per calendar year) • Durable medical equipment • Physical, occupational, cognitive, speech and audiology therapy (up to 45 visits per calendar year) • Chiropractic services (20 visits per calendar year) • Advanced imaging (PET, MRI, MRA, CAT, SPECT) • Urgent Care • Retail clinics	100% after deductible	70% after deductible
• Advanced imaging in emergency room (PET, MRI, MRA, CAT, SPECT) (3) • Ambulance (3)	100% after deductible	100% after in-network deductible
• Maternity	Same as any other condition	Same as any other condition
Mental Health		
• Inpatient services • Outpatient services	100% after deductible	70% after deductible
Alcohol and Chemical Dependency		
• Inpatient services • Outpatient services	100% after deductible	70% after deductible

Additional Coverage Information

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

LFUCG - HSA2

Kentucky

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 Summary Plan Description.

	IF YOU USE IN-NETWORK PROVIDERS		IF YOU USE OUT-OF-NETWORK PROVIDERS	
Embedded Annual Deductible (5) (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. *Once your in-network deductible is satisfied, you are responsible for 20% of eligible medical expenses.)	Individual $2,500	Family (4) $5,000	Individual $7,500	Family (4) $15,000
Embedded Maximum Out-of-Pocket Expense Limit (5) (The Maximum Out-of-Pocket Expense Limit is calculated on a calendar year basis, and does include deductibles)	Individual $5,000	Family $10,000	Individual $9,000	Family $18,000
Preventive Care • Preventive office visits (up to age 18) • Preventive immunizations (up to age 18) • Preventive office visit (18 years and above) • Preventive mammography • Preventive Pap Smears • Preventive outpatient laboratory tests • Preventive endoscopy • Preventive prostate screenings • Preventive flu/pneumonia immunization	100%		50% after deductible	

	IF YOU USE IN-NETWORK PROVIDERS	IF YOU USE OUT-OF-NETWORK PROVIDERS
Physician Services (1)		
• 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 • Inpatient/outpatient services • Allergy injections • Physician surgery	80% after deductible	50% after deductible
• Physician visit to emergency room (3)	80% after deductible	80% after in-network deductible
Facility Services		
• Inpatient care (semiprivate room and board, nursing care, ICU) • Outpatient surgery • Outpatient nonsurgical care • Emergency room visit (copayment is waived if admitted) (3)	80% after deductible	50% after deductible
Prescription Drugs	80% after deductible	50% after deductible
Other Medical Services (2)		
• Skilled nursing facility (up to 60 days per calendar year) • Home health care (up to 100 visits per calendar year) • Durable medical equipment • Physical, occupational, cognitive, speech and audiology therapy (up to 45 visits per calendar year) • Chiropractic services (20 visits per calendar year) • Advanced imaging (PET, MRI, MRA, CAT, SPECT) • Urgent Care • Retail clinics	80% after deductible	50% after deductible
• Advanced imaging in emergency room (PET, MRI, MRA, CAT, SPECT) (3) • Ambulance (3)	80% after deductible	80% after in-net*work deductible
• Maternity	Same as any other condition	Same as any other condition
Mental Health		
• Inpatient services • Outpatient services	80% after deductible	50% after deductible
Alcohol and Chemical Dependency		
• Inpatient services • Outpatient services	80% after deductible	50% after deductible

Additional Coverage Information

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

LFUCG PPO-1

Kentucky

80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Preventive Care (1)		
• Routine immunizations (to age 18) • Routine Pap smear • Annual routine mammogram • Routine lab test and X-ray • Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy) • Routine adult physical exam (18 years and above) • Routine child exams (to age 18)	100%	50% after deductible
Physician Services (1)		
• Office visits • Diagnostic, lab and X-rays (copayment does not apply) • Allergy testing (copayment does not apply)	100% after $15 primary care physician/ $30 specialist copayment per visit	50% after deductible
• Inpatient services • Outpatient services • Office surgery	80% after deductible	50% after deductible
• Emergency room physician visits (2)	80% after deductible	80% after deductible
• Allergy injections and nonroutine injections other than allergy	100% after $5 copayment per visit	50% after deductible
Facility Services		
• Inpatient hospital care • Outpatient surgery • Outpatient nonsurgical care • Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)	80% after deductible	50% after deductible
• Hospital emergency services (emergency room copayment waived if admitted) (2)	80% after deductible	80% after deductible

80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Other Medical Services (3)		
• Skilled nursing facility (up to 60 day limit per calendar year) • Home health (up to 100 visits per calendar year) • Physical, occupational, cognitive, speech and audiology therapy (subject to combined limit for all therapy services up to 45 visits per calendar year) • Durable medical equipment	80% after deductible	50% after deductible
• Urgent care facility	100% after $60 copayment per visit	50% after deductible
• Chiropractic services (up to 20 visits per calendar year)	100% after primary care physician copayment per visit	50% after deductible
• Ambulance (2)	80% after deductible	80% after participating deductible
• Transplant services	Same as any other covered condition when services are received from a Transplant Network provider (when services are received from a Transplant Network provider)	Same as any other covered condition (covered expenses are limited to a maximum benefit of $35,000 per transplant)
Deductible and Out-of-Pocket Maximum Accumulation Methods		
• Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately		
Deductible (per calendar year; copayments do not apply)		
• Individual	$500	Three times individual participating deductible
• Family (4)	Two times individual participating deductible	Three times family participating deductible
Out-of-Pocket Maximum (per calendar year; includes deductible; copayments do apply)		
• Individual	$1,500	Three times individual participating out-of-pocket maximum
• Family	Two times individual participating out-of-pocket maximum	Three times family participating out-of-pocket maximum
Lifetime Maximum Benefit	Unlimited (participating and nonparticipating combined)	
Behavioral Health (mental health and substance abuse)		
• Inpatient services • Outpatient services	Same as any other covered condition	Same as any other covered condition

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.

Participating 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 Summary Plan Description for more information on medical necessity and other specific plan benefits.

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

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

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

Kentucky

80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Preventive Care (1)		
• Routine immunizations (to age 18) • Routine Pap smear • Annual routine mammogram • Routine lab test and X-ray • Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy) • Routine adult physical exam (18 years and above) • Routine child exams (to age 18)	100%	50% after deductible
Physician Services (1)		
• Office visits • Diagnostic, lab and X-rays (copayment does not apply) • Allergy testing (copayment does not apply)	100% after $30 primary care physician/ $60 specialist copayment per visit	50% after deductible
• Inpatient services • Outpatient services • Office surgery	80% after deductible	50% after deductible
• Emergency room physician visits (2)	80% after deductible	80% after deductible
• Allergy injections and nonroutine injections other than allergy	100% after $5 copayment per visit	50% after deductible
Facility Services		
• Inpatient hospital care • Outpatient surgery • Outpatient nonsurgical care • Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT)	80% after deductible	50% after deductible
• Hospital emergency services (emergency room copayment waived if admitted) (2)	80% after deductible	80% after deductible

80/50 PLAN	PLAN PAYS FOR SERVICES AT PARTICIPATING PROVIDERS	PLAN PAYS FOR SERVICES AT NONPARTICIPATING PROVIDERS
Other Medical Services (3)		
• Skilled nursing facility (up to 60 day limit per calendar year) • Home health (up to 100 visits per calendar year) • Physical, occupational, cognitive, speech and audiology therapy (subject to combined limit for all therapy services up to 45 visits per calendar year) • Durable medical equipment	80% after deductible	50% after deductible
• Urgent care facility	100% after $100 copayment per visit	50% after deductible
• Chiropractic services (up to 20 visits per calendar year)	100% after primary care physician copayment per visit	50% after deductible
• Ambulance (2)	80% after deductible	80% after participating deductible
• Transplant services	Same as any other covered condition when services are received from a Transplant Network provider (when services are received from a Transplant Network provider)	Same as any other covered condition (covered expenses are limited to a maximum benefit of $35,000 per transplant)
Deductible and Out-of-Pocket Maximum Accumulation Methods		
• Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately		
Deductible (per calendar year; copayments do not apply)		
• Individual	$2,000	Three times individual participating deductible
• Family (4)	Two times individual participating deductible	Three times family participating deductible
Out-of-Pocket Maximum (per calendar year; includes deductible; copayments do apply)		
• Individual	$4,000	Three times individual participating out-of-pocket maximum
• Family	Two times individual participating out-of-pocket maximum	Three times family participating out-of-pocket maximum
Lifetime Maximum Benefit	Unlimited (participating and nonparticipating combined)	
Behavioral Health (mental health and substance abuse)		
• Inpatient services • Outpatient services	Same as any other covered condition	Same as any other covered condition

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