Dental maximum allowable fee (MAF) and in-network fee schedule (INFS) options
Explaining out-of-network reimbursement limits

Many of Humana's dental plans allow employers to select how Humana will process eligible employees' claims for covered services when using an out-of- network provider. For those plans, there are two unique choices.

Reimbursement limits are based on:
1. Maximum allowable fee (MAF), or
2. In-network fee schedule (INFS)

In both plans, if a member sees an in-network provider, the reimbursement limit is based upon the provider's negotiated fee. The members will not receive a bill for charges more than the negotiated fee.

The key difference between these plans is how Humana processes a claim for services received from out-of-network providers.

Maximum allowable fee (MAF)

Out-of-network providers establish their own fees. The same service can cost more or less from one provider to another and from one geographic area to another.

All insurance carriers define a reimbursement limit for out-of-network covered services. Most set this limit within specific geographic regions that usually vary from one carrier to another. The variables within this process make it difficult to compare one carrier's reimbursement limits to another.

Humana uses a combination of internal and external data, including data from Fair Health, Inc.[1], to establish out-of-network reimbursement limits by geographic region. This reimbursement limit is called the maximum allowable fee (MAF).

Competitors may refer to this type of reimbursement methodology as Usual and Customary (U&C) or Usual, Customary, and Reasonable (UCR). Sometimes, they may also state a percentage of usual and customary; typically at the 90th percentile.

With a MAF plan, Humana will process out-of-network claims according to the MAF schedule established by Humana. The member is responsible for the amount charged above the MAF amount.

In-network fee schedule (INFS)

The INFS plan uses an average of the negotiated in-network fees to establish the out-of-network reimbursement limits by geographic region. Negotiated in-network provider fees are generally lower than out-of-network fees.

With an INFS plan, Humana will process out-of-network claims according to the INFS schedule established by Humana. The member is responsible for the amount charged above the INFS amount.

Competitors may refer to this type of reimbursement methodology as Maximum Allowable Charge (MAC). Sometimes, they may also state their MAC plan pays at some percentage of U&C. Humana's INFS reimbursement does not use a percentage of U&C.

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[1] Fairhealthus.org

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How to choose between the two?

Premiums for an INFS plan are generally rated lower than a MAF plan. However, a member who receives services from an out-of-network provider may pay more.

When choosing between the MAF and INFS plan,

1. Compare premium rates
2. Review the dental network provider directory[2]
   - If employees will have access to and use in-network providers, an INFS plan may be a good value.

Sample scenario

See this sample based scenario for an amalgam filling. The charges and reimbursement limits are fictitious; however, they illustrate the difference between the two reimbursement limit options.

This sample is using a Traditional Preferred 185 plan. The coinsurance levels for this plan differ by the type of service:

- Preventive service – 100 percent
- Basic service – 80 percent
- Major service – 50 percent

A Traditional Preferred plan pays the same coinsurance amount for in- or out-of-network providers. The reimbursement limit for an in-network provider is always going to be equal to the negotiated fee (which is what the provider will charge). An amalgam filling is a basic service, so the coinsurance level is 80 percent.

Benefit illustration only

IN OR OUT OF NETWORK	IN NETWORK		OUT OF NETWORK	
MAF or INFS	MAF	INFS	MAF	INFS
Charge amount	$170	$170	$190	$190
Reimbursement limit	$170	$170	$185	$170
Coinsurance level	80%	80%	80%	80%
Calculation	$170 x 80% = $136	$170 x 80% = $136	$185 x 80% = $148	$170 x 80% = $136
Humana payment	$136	$136	$148	$136
Member balance	$34	$34	$42	$54

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Waiting periods, limitations, and exclusions may apply. This is not a complete disclosure of the plan qualifications and limitations. Specific limitation and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the plan selection. Insured or administered by HumanaDental Insurance Company, Humana Insurance Company of New York, or The Dental Concern, Inc.

[2]Provider participation in Humana's network is subject to change and should be verified prior to services being provided. While every effort has been made to provide the most accurate and up-to-date information, in-network doctors and network composition can change without notice.

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