

# NPOS - Copay Plan: Clermont County Benefit Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016-12/31/2016

Coverage for: Single & Family Plan Type: NPOS



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 1-513-732-7981.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-Network (PAR) <b>providers: \$1,000</b> single/ <b>\$2,000</b> family. Out-of-Network (Non-PAR) <b>providers: \$2,000</b> single/ <b>\$4,000</b> family. <b>Ded</b> doesn't apply to PAR preventive care. <b>Coins &amp; copays</b> don't apply to <b>deductible</b> .	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Medical: PAR <b>providers: \$3,000</b> single/ <b>\$6,000</b> family; Non-PAR <b>providers: \$6,000</b> single/ <b>\$12,000</b> family. Plan Maximum Out-of-Pocket PAR <b>providers: \$6,250</b> single / <b>\$12,500</b> family; Non-PAR <b>providers: NA</b> .	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<b>Premiums</b> , balance-billed charges, penalties, Non-PAR <b>copays</b> , non-Humana Nat'l Transplant Network transplants, & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.humana.com">www.humana.com</a> for a list of PAR <b>providers</b> .	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <b>specialist</b> .	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PAR **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u>	40% after <u>deductible</u>	—————none—————
	<b>Specialist</b> visit	\$40 <u>copayment</u>	40% after <u>deductible</u>	—————none—————
	Other practitioner office visit: -Chiropractic exams, manipulations & therapies -Chiropractic lab & x-ray	\$40 <u>copayment</u> No charge	40% after <u>deductible</u> 40% after <u>deductible</u>	Limited to 12 visits/calendar year.
	Preventive care/screening/immunization	No charge	40% after <u>deductible</u>	Limited to 1 colonoscopy /calendar year regardless of diagnosis
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% after <u>deductible</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% after <u>deductible</u>	40% after <u>deductible</u>	<b>Prior authorization</b> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only)

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<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.humana.com">www.humana.com</a>.</p>	Level 1 – Low cost drugs Retail (30 days) Retail (90 days) Mail (90 days)	\$10 <b>copayment</b> \$30 <b>copayment</b> \$20 <b>copayment</b>	PAR copay + 30% + the difference between the default rate and the Non-PAR pharmacy charge/Rx	- 30 day supply (retail). - 90 day supply (mail only). -Pharmacy <b>Out-of-pocket</b> PAR <b>providers: \$3,500</b> single/\$ <b>7,000</b> family; Non-PAR <b>providers: NA</b> - No charge for retail flu and pneumonia immunizations, drugs on the Women’s Healthcare Drug List, HCR preventative medication in addition to Polio, DTaP, MMR, Tetanus and Zostavax Vaccine. - If you request a brand-name drug and a generic is available, you will be responsible for the cost differential between the brand-name drug and the generic plus any applicable <b>copayments</b> . - Some medications will require <b>prior authorization</b> , step therapy or may have dispensing limits.
	Level 2 – High cost drugs Retail (30 days) Retail (90 days) Mail (90 days)	\$30 <b>copayment</b> \$90 <b>copayment</b> \$60 <b>copayment</b>		
	Level 3 - Higher cost drugs Retail (30 days) Retail (90 days) Mail (90 days)	\$50 <b>copayment</b> \$150 <b>copayment</b> \$100 <b>copayment</b>		
	Level 4 - Highest cost drugs Retail (30 days) Retail (90 days) Mail (90 days)	25% max \$250 25% max \$750 25% max \$500		
	Specialty drugs: - Obtained at a pharmacy - Obtained by a qualified practitioner through Specialty Rx and administered in their office - Obtained under medical benefits	Same as Level 1, 2, 3 or 4 No charge  Medical benefits apply		
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% after <b>deductible</b>	40% after <b>deductible</b>	<b>Prior authorization</b> is required. Failure to do so will reduce <b>coins</b> to 50% (Non-PAR only)
	Physician/surgeon fees	20% after <b>deductible</b>	40% after <b>deductible</b>	none

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If you need immediate medical attention	Emergency room services	\$200 <u>copayment</u>	\$200 <u>copayment</u>	<u>Copayment</u> waived if admitted inpatient
	<u>Emergency medical transportation</u>	No charge	No charge	—————none—————
	<u>Urgent care</u>	\$35 <u>copayment</u>	40% after <u>deductible</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after <u>deductible</u>	40% after <u>deductible</u>	<u>Prior authorization</u> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only)
	Physician/surgeon fee	20% after <u>deductible</u>	40% after <u>deductible</u>	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 <u>copayment</u>	40% after <u>deductible</u>	—————none—————
	Mental/Behavioral health inpatient services	20% after <u>deductible</u>	40% after <u>deductible</u>	<u>Prior authorization</u> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only)
	Substance use disorder outpatient services	\$20 <u>copayment</u>	40% after <u>deductible</u>	—————none—————
	Substance use disorder inpatient services	20% after <u>deductible</u>	40% after <u>deductible</u>	<u>Prior authorization</u> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only)
If you are pregnant	Prenatal and postnatal care	20% after <u>deductible</u>	40% after <u>deductible</u>	—————none—————
	Delivery and all inpatient services	20% after <u>deductible</u>	40% after <u>deductible</u>	—————none—————

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If you need help recovering or have other special health needs	<u>Home health care</u>	20% after <u>deductible</u>	40% after <u>deductible</u>	Limited to 60 visits/calendar year <b>Prior authorization</b> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only)
	<u>Rehabilitation services</u>	\$20 <u>copayment</u>	40% after <u>deductible</u>	Speech and Cognitive therapies limited to 60 visits/ calendar year Physical and Occupational Therapies limited to 60 visits per year Cardiac Rehab Phase II limited to 36 visits/calendar year <b>Prior authorization</b> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only)
	<u>Habilitation services</u>	\$20 <u>copayment</u>	40% after <u>deductible</u>	<b>Prior authorization</b> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only)
	<u>Skilled nursing care</u>	20% after <u>deductible</u>	40% after <u>deductible</u>	Limited to 120 days/calendar year.
	<u>Durable medical equipment</u>	20% after <u>deductible</u>	40% after <u>deductible</u>	<b>Prior authorization</b> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only) Wigs are covered with no charge to the member. There is a \$500 limit per every 3 years.
	<u>Hospice service</u>	No Charge	No Charge	<b>Prior authorization</b> is required. Failure to do so will reduce <u>coins</u> to 50% (Non-PAR only)
If your child needs dental or eye care	Eye exam	No Charge	40% after deductible	Limited to 1 exam & 1 refraction/ calendar year Refraction - \$20 <u>copay</u> in an office visit setting and 20% after <u>deductible</u> in an outpatient setting

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	Glasses	Not covered	Not covered	No coverage for glasses.
	Dental check-up	Not covered	Not covered	No coverage for dental check-ups.

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Behavioral health half-way house services
- Dental care (adult and child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Vision therapy
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limited to 12 visits/calendar year)
- Bariatric surgery (PAR services only, 20% after deductible, limited to \$20,000/ lifetime)
- Chiropractic care (limited to 12 visits/ year)
- Cosmetic surgery (Requires prior auth. Services will only be considered if due to a bodily injury or illness and functional impairment is present.)
- Dependent daughter maternity
- Routine eye care (adult and child)-Limited to one examination and one refraction/calendar year

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### **Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-513-732-7981. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### **Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$5,280**
- **Patient pays \$2,260**

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,000
Copays	\$140
Coinsurance	\$1,120
Limits or exclusions	\$0
<b>Total</b>	<b>\$2,260</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$3,210**
- **Patient pays \$2,190**

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,000
Copays	\$1,170
Coinsurance	\$0
Limits or exclusions	\$20
<b>Total</b>	<b>\$2,190</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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