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 1-985-230-6532.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Tier 1: **$250** single/**$500** family; Tier 2: **$1,250** single/**$3,250** family; Tier 3: **$1,250** single/**$3,250** family; **Coinsurance** & **copayments** don't apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Tier 1: **$5,000** single/**$10,000** family; Tier 2: **$5,000** single/**$10,000** family; Tier 3: **Unlimited** single/**Unlimited** family	The **out-of-pocket limit** 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 out–of–pocket limit?	**Premiums**, balance-billed charges, health care this Plan doesn't cover, penalties, Tier 3 **copays**, Non-Humana Nat'l Transplant Network transplants & amounts over **allowed amount**.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
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 network of providers?	Yes. For a list of Humana In-Network **providers**, see www.humana.com or call 1-866-427-7478. For a list of North Oaks In-Network **providers**, call North Oaks at 1-985-230-6532.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** 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 7. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-985-230-6532.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

- **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 North Oaks In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a North Oaks Humana In-Network Provider	Your cost if you use a Humana In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 **copay**/visit	$25 **copay**/visit	50% after **deductible**	————none————
	Specialist visit	$40 **copay**/visit	$40 **copay**/visit	50% after **deductible**	————none————
	Other practitioner office visit (chiropractor)	10% after **deductible**	10% after tier 1 **deductible**	50% after **deductible**	Coverage is limited to 30 visits, combined with office visits, therapies, lab/x-ray and manipulations.
	Preventive care/screening/ immunization	No charge	No charge	50% after **deductible**	No coverage for adult immunizations with exception of shingles, meningitis, HPV, flu, pneumonia & H1N1.

If you have a test	Diagnostic test, xray, blood work -Clinic -Inpatient, Outpatient and Independent Lab - Emergency Room	No charge 10% after **deductible** 10% after **deductible**	No charge 30% after **deductible** 10% after tier 1 **ded**	50% after **deductible** 50% after **deductible** 10% after tier 1 **ded**	-Emergency room, non-emergency Out-of-Network benefit is: 50% after **deductible**. Prior authorization is required for advanced imaging. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
	Imaging (CT/PET scans, MRIs): - Clinic - Other than Clinic	No charge 10% after **deductible**	30% after **deductible** 30% after **deductible**	50% after **deductible** 50% after **deductible**	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com	Level 1 -North Oaks & Humana Mail Retail & Specialty drugs /90 Day - Other Humana Network Pharmacy Retail & Specialty Drugs	$10 **copay**/script $20 **copay**/90 day script	$20 **copay**/script	In-Network **copay** + 30%/prescription + the difference between the default rate and the Non-PAR pharmacy charge/Rx	30 day supply (retail). 90 day supply for 2X copay only available at North Oaks & Humana Mail. Retail Flu & Pneumonia Immunizations, HCR Women's Preventive, HCR Preventive: No charge. Compound Drugs: 45% coinsurance (in-network); 45% coinsurance + 30% (out-of-network) Some medications will require prior authorization, step therapy or dispensing limits. Out-of-Pocket max of $5,000 per covered person for In-network drug purchases; unlimited for Out-of-network drug purchases.
	Level 2 -North Oaks & Humana Mail Retail & Specialty drugs /90 Day -Other Humana Network Pharmacy Retail & Specialty Drugs	$20 **copay**/script $40 **copay**/90 day script	$40 **copay**/script		
	Level 3 -North Oaks & Humana Mail Retail & Specialty drugs/90 Day -Other Humana Network Pharmacy Retail & Specialty Drugs	$40 **copay**/script $80 **copay**/90 day script	$60 **copay**/script		
	Level 4 -North Oaks & Humana Mail Retail & Specialty drugs/90 Day -Other Humana Network Pharmacy Retail & Specialty Drugs	25% **copay**/script	45% **copay**/script		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after **deductible**	30% after **deductible**	50% after **deductible**	Prior authorization may be required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
	Physician/surgeon fees	10% after **deductible**	30% after **deductible**	50% after **deductible**	

If you need immediate medical attention	Emergency room services (**copay** waived if admitted)	$100 **copay** then 10% after **deductible**	$100 **copay** then 10% after tier 1 **deductible**	$100 **copay** then 10% after tier 1 **deductible**	Non-emergency Out-of-Network benefit is: $100 **copay** then 50% after **deductible**.
	Emergency medical transportation	10% after **deductible**	10% after tier 1 **deductible**	10% after tier 1 **deductible**	————none————
	Urgent care	10% after **deductible**	10% after tier 1 **deductible**	50% after **deductible**	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 **copay** per day for the first 3 days, then 10% after **deductible**	$200 **copay** per day for the first 3 days, then 30% after **deductible**	$200 **copay** per day for the first 3 days, then 50% after **deductible**	Prior authorization is required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
	Physician/surgeon fee	10% after **deductible**	30% after **deductible**	50% after **deductible**	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 **copay**/visit	$25 **copay**/visit	50% after **deductible**	Marriage counseling copay for Tiers 1 & 2 is $40 per visit.
	Mental/Behavioral health inpatient services	$200 **copay** per day for the first 3 days, then 10% after **deductible**	$200 **copay** per day for the first 3 days, then 10% after tier 1 **deductible**	$200 **copay** per day for the first 3 days, then 50% after **deductible**	Prior authorization is required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
	Substance abuse disorder outpatient services	$25 **copay**/visit	$25 **copay**/visit	50% after **deductible**	————none————
	Substance abuse disorder inpatient services	$200 **copay** per day for the first 3 days, then 10% after **deductible**	$200 **copay** per day for the first 3 days, then 10% after tier 1 **deductible**	$200 **copay** per day for the first 3 days, then 50% after **deductible**	Prior authorization is required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
If you are pregnant	Prenatal and postnatal care (office visit and delivery)	$40 **copay**/initial visit then 10% after **deductible**	$40 **copay**/initial visit then 30% after **deductible**	50% after **deductible**	Office visit **copayment** applies to the initial visit only.
	Delivery and all inpatient services	$200 **copay** per day for the first 3 days, then 10% after **deductible**	$200 **copay** per day for the first 3 days, then 30% after **deductible**	$200 **copay** per day for the first 3 days, then 50% after **deductible**	Prior authorization may be required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.

If you need help recovering or have other special health needs	Home health care	10% after **deductible**	10% after tier 1 **deductible**	50% after **deductible**	Prior authorization is required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
	Rehabilitation services (clinic and outpatient)	10% after **deductible**	30% after **deductible**	50% after **deductible**	Prior authorization may be required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
	Habilitation services	10% after **deductible**	30% after **deductible**	50% after **deductible**	
	Skilled nursing care	$200 **copay** per day for the first 3 days, then 10% after **deductible**	$200 **copay** per day for the first 3 days, then 10% after tier 1 **deductible**	$200 **copay** per day for the first 3 days, then 50% after **deductible**	Coverage is limited to 60 days. Prior authorization is required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
	Durable medical equipment, Prosthetics and Wigs	10% after **deductible**	10% after tier 1 **deductible**	50% after **deductible**	Prior authorization is required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
	Hospice service	Inpatient: $200 **copay** per day for the first 3 days, and 10% after **deductible**. Outpatient: 10% after **deductible**.	Inpatient: $200 **copay** per day for the first 3 days, and 30% after **deductible**. Outpatient: 30% after **deductible**.	Inpatient: $200 **copay** per day for the first 3 days, and 50% after **deductible**. Outpatient: 50% after **deductible**.	Prior authorization is required. Benefits reduced to 50% after **deductible** if prior auth. not obtained.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	No coverage for eye exams. Vision screenings for children are covered.
	Glasses	Not covered	Not covered	Not covered	No coverage for glasses, except initial pair after cataract surgery. See plan for benefits.
	Dental check-up	Not covered	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.)

- Acupuncture
- Bulk powders
- Dental care (Adult and Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Child)
- Routine foot care
- Routine hearing exams and testing
- Weight loss programs
- Wigs, unless for chemotherapy, radiation and alopecia patients, limited to $300 per lifetime

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.)

- Bariatric surgery (Limited to $20,000 per lifetime)
- Chiropractic care (Limited to 30 visits/year)
- Cosmetic surgery (Requires prior auth., and only considered if due to a bodily injury or illness and a functional impairment is present)
- Hearing aids (for a child under the age of 18 if hearing aids are fitted and dispensed by a licensed audiologist or hearing aid specialist.)
- Private-duty nursing (inpatient hospital only)

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 1-985-230-6532. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 X61565 or 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 file an **appeal** or file a **grievance**. See plan document for appeal process. For questions about your rights, this notice, or assistance, you can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.

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** $6,300
- **Patient pays** $1,240

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
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$540
Coinsurance	$450
Limits or exclusions	$0
Total	**$1,240**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,870
- **Patient pays** $1,530

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
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$1,260
Coinsurance	$0
Limits or exclusions	$20
Total	**$1,530**

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.