The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 1-985-230-6532. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copays, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol/ebsa/healthreform.com or call 1-985-230-6532 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: **$350** single/**$500** family; Tier 2: **$1,250** single/**$3,250** family; Tier 3: **$1,250** single/**$3,250** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	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 in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, & health care this plan doesn't cover, penalties, Tier 3 copays, Non-Humana Nat'l Transplant Network services & amounts over allowed amount.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of Humana In-Network **providers**, see Humana.com or call 1-866-427-7478. For North Oaks In-Network **providers**, call North Oaks at 1-985-230-6532.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you 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 and the plan will pay according to plan schedule of benefits.

All **copays** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use a North Oaks Humana In-Network Provider (You will pay the least)	Your cost if you use a Humana In-Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
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% coinsurance	None
	Specialist visit	$45 copay/ visit	$45 copay/ visit	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work) -Clinic -Inpatient and Independent Lab -Outpatient Lab -Emergency Room	No Charge 10% coinsurance $10 copay/ per test 10% coinsurance after tier 1 deductible	No Charge 30% coinsurance 30% coinsurance 10% coinsurance after tier 1 deductible	50% coinsurance 50% coinsurance 50% coinsurance 10% coinsurance after tier 1 deductible	-Emergency room, non-emergency out-of-Network benefit is: 50% after deductible
	Imaging (CT/PET scans, MRIs) -Clinic -Other than Clinic	No Charge 10% coinsurance	30% coinsurance 30% coinsurance	50% coinsurance 50% coinsurance	Preauth is required for Advanced Imaging. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Your cost if you use an Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Your cost if you use a North Oaks Humana In-Network Provider (You will pay the least)	Your cost if you use a Humana In-Network Provider		
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	$10 copay/ prescription $20 copay / 90 day script	$20 copay	Tier 2 Network copay + 30%/prescription + the difference between the default rate and the Non-Par pharmacy charge	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: 35% coinsurance at North Oaks and Humana Mail Retail (In-Network); 45% coinsurance For all other (In-Network); 45% coinsurance +30% (Out –of-Network) Some medications will require prior authorization, step therapy or may have dispensing limits. Out-of-Pocket max $5,000 per covered person per year for drugs purchased In –Network. Out-of-Pocket is unlimited for Out-of-Network drug purchases.
	Level 2:North Oaks & Humana Mail Retail & Specialty drugs / 90 Day -Other Humana Network Pharmacy Retail & Specialty	$20 copay/ prescription $40 copay / 90 day script	$40 copay		
	Level 3:North Oaks & Humana Mail Retail & Specialty drugs / 90 Day -Other Humana Network Pharmacy Retail & Specialty	$40 copay/ prescription $80 copay / 90 day script	$60 copay		
	Level 4:North Oaks & Humana Mail Retail & Specialty drugs / 90 Day -Other Humana Network Pharmacy Retail & Specialty	25% copay/ prescription	45% copay/ script		

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use a North Oaks Humana In-Network Provider (You will pay the least)	Your cost if you use a Humana In-Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	50% coinsurance	Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$125 copay then 10% coinsurance	$125 copay then 10% coinsurance after tier 1 deductible	$125 copay then 10% coinsurance after tier 1 deductible	Out-of-Network for a non-emergency is a $125 copay then 50% after Out-of-Network deductible
	Emergency medical transportation	10% coinsurance	10% coinsurance after tier 1 deductible	10% coinsurance after tier 1 deductible	None
	Urgent care	10% coinsurance	10% after tier 1 deductible	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per day for the first 3 days, then 10% coinsurance	$200 copay per day for the first 3 days, then 30% coinsurance	$200 copay per day for the first 3 days, then 50% coinsurance	Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use a North Oaks Humana In-Network Provider (You will pay the least)	Your cost if you use a Humana In-Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	$25 copay/visit	50% coinsurance	Marriage Counseling copay for Tiers 1 & 2 is $45 per visit.
	Inpatient services	$200 copay per day for the first 3 days, then 10% coinsurance	$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% coinsurance	Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Childbirth/delivery professional services	$45 copay / then 10% coinsurance	$45 copay / then 30% coinsurance	50% coinsurance	Office visit copay only applies to initial visit.
	Childbirth/delivery facility services	$200 copay per day for the first 3 days, then 10% coinsurance	$200 copay per day for the first 3 days, then 30% coinsurance	$200 copay per day for the first 3 days, then 50% coinsurance	Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance after tier 1 deductible	50% coinsurance	Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	10% coinsurance	30% coinsurance	50% coinsurance	
	Habilitation services	10% coinsurance	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use a North Oaks Humana In-Network Provider (You will pay the least)	Your cost if you use a Humana In-Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	$200 copay per day for the first 3 days, then 10% coinsurance	$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% coinsurance	Coverage is limited to 60 days. Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	10% coinsurance	10% after tier 1 deductible	50% coinsurance	Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	Inpatient: $200 copay per day for the first 3 days, then 10% after deductible Outpatient: 10% after deductible	Inpatient: $200 copay per day for the first 3 days, then 30% after deductible Outpatient: 30% after deductible	Inpatient: $200 copay per day for the first 3 days, then 50% after deductible Outpatient: 50% after deductible	Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Vision screenings for children are covered.
	Children's glasses	Not Covered	Not Covered	Not Covered	See plan for benefits.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bulk powders
- Dental care (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & 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 (Limitations may apply to these services. This isn't a complete list. Please see your document.)

- Bariatric surgery (Limited to $20,000 per lifetime)
- Chiropractic care (Limited to 30 visits/year)
- ABA Therapy
- 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: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is1-866-444-3272. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.com.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al [1-866-427-7478 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-866-427-7478 (TTY: 711].

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [1-866-427-7478 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-866-427-7478 (TTY: 711)

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$1,200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**