

**North Oaks Health System: PCA Plan**


Coverage for: Individual +Family | Plan Type: PCA



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, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-985-230-6532 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Tier 1: <b>\$1,500</b> Single/ <b>\$4,500</b> Family; Tier 2: <b>\$3,500</b> Single/ <b>\$10,500</b> Family; Tier 3: <b>\$6,000</b> Single/ <b>\$18,000</b> Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <u>deductibles</u> for specific services?	No.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Tier 1: <b>\$4,700</b> Single/ <b>\$9,400</b> Family; Tier 2: <b>\$8,000</b> Single/ <b>\$16,000</b> Family; Tier 3: <b>Unlimited</b> Single/ <b>Unlimited</b> Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>Balance-billing charges</u> , Health care this <u>plan</u> doesn't cover, Penalties, Tier 3 <u>copays</u> , <u>Non-network Transplant</u> , <u>Non-Network Prescription Drugs</u> , <u>Non-Network specialty Drugs</u> , amounts over allowed amount & non-network immune effector cell therapy.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.humana.com/directories">www.humana.com/directories</a> or call 1-866-4ASSIST (427-7478) for a list of Humana <u>network providers</u> . For North Oaks In – Network <u>providers</u> , Call North Oaks at 1-985-230-6532.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan and the plan will pay according plan schedule of benefits.

 All **copayment** 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 In-Network Provider (You will pay the least)	Your cost if you use an 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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge.	No charge.	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) -Clinic	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Non-emergency Out-of-network benefit is: 50% after Out- of- Network <u>deductible</u>
	-Inpatient and Independent Lab	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	-Outpatient Lab	\$10 <u>copay</u> /per test	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	-Emergency Room True Emergency	20% <u>coinsurance</u> after Tier 1 <u>deductible</u>	20% <u>coinsurance</u> after Tier 1 <u>deductible</u>	20% <u>coinsurance</u> after Tier 1 <u>deductible</u>	
	Imaging (CT/PET scans, MRIs) -Clinic -Other than Clinic	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	<u>Preauth</u> is required for Advanced Imaging. If you don't get <u>preauth</u> , benefits could be reduced by 50% of total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use a North Oaks In-Network Provider (You will pay the least)	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
		North Oaks Prescription Centers	Express Scripts Pharmacies	Non- North Oaks or Express Scripts Pharmacy	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or 1-800-334-8134	Level 1 Generic:	\$7.50 copay (1-30 day supply) \$15 copay (31-90 day supply)	\$20 copay (Retail 1-30 day supply) \$15 copay (Mail Order 31-90 day supply)	Not covered	--30 day supply (retail) -90 day supply for 2x copay only available at North Oaks and ESI Mail Order - Retail Flu & Pneumonia Immunizations, HCR Women's Preventive, & HCR Preventive: No charge. - Some medications will require prior authorization, step therapy or may have dispensing limits. - Out-of-Pocket max \$4,700 per covered person per year for drugs purchased at North Oaks Prescription Centers. \$8,000 per covered person per year for drugs purchased at Express Script Pharmacies. Specialty medications are limited to a 30-day supply and must be ordered from North Oaks Prescription Centers at 985-230-3383 or 985-230-7880. Mail order not available
	Level 2 Preferred Brand Name Drugs:	\$15 copay (1-30 day supply) \$30 copay (31-90 day supply)	\$40 copay (Retail 1-30 day supply) \$30 copay (Mail Order 31-90 day supply)	Not covered	
	Level 3 Non Preferred Brand Name Drugs:	\$30 copay (1-30 day supply) \$60 copay (31-90 day supply)	\$60 copay (Retail 1-30 day supply) \$60 copay (Mail Order 31-90 day supply)	Not covered	
	Specialty Medication	\$150 copay (1-30 day supply only)	Not applicable	Not covered	
	Compound Medications	35% <u>coinsurance</u>	45% <u>coinsurance</u>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	If you don't get <u>preauth</u> , benefits could be reduced by 50% of total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use a North Oaks In-Network Provider (You will pay the least)	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u> True Emergency	\$150 <u>copay</u> then 20% <u>coinsurance</u>	\$150 <u>copay</u> then 20% after Tier 1 <u>deductible</u>	\$150 <u>copay</u> then 20% after Tier 1 <u>deductible</u>	Out-of-Network for a non-emergency is a \$150 copay then 50% after Out-of-Network <u>deductible</u>
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% after Tier 1 <u>deductible</u>	20% after Tier 1 <u>deductible</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% after Tier 1 <u>deductible</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay</u> then 20% <u>coinsurance</u>	\$200 <u>copay</u> per day for the first 3 days, 40% <u>coinsurance</u>	\$200 <u>copay</u> per day for the first 3 days, then 50% <u>coinsurance</u>	<u>Preauth</u> is required for Advanced Imaging. If you don't get <u>preauth</u> , benefits could be reduced by 50% of total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Inpatient services	\$200 <u>copay</u> then 20% <u>coinsurance</u>	\$200 <u>copay</u> , then 20% after tier 1 deductible	\$200 <u>copay</u> per day for the first 3 days, then 50% <u>coinsurance</u>	<u>Preauth</u> is required for Advanced Imaging. If you don't get <u>preauth</u> , benefits could be reduced by 50% of total cost of the service.
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	\$200 <u>copay</u> then 20% <u>coinsurance</u>	\$200 <u>copay</u> per day for the first 3 days, 40% <u>coinsurance</u>	\$200 <u>copay</u> per day for the first 3 days, then 50% <u>coinsurance</u>	If you don't get <u>preauth</u> , benefits could be reduced by 50% of total cost of the service.
If you need help	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> after	50% <u>coinsurance</u>	- 100 visits per year

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use a North Oaks In-Network Provider (You will pay the least)	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider (You will pay the most)	
recovering or have other special health needs			Tier 1 <u>deductible</u>		- <u>Preauthorization</u> may be required - if not obtained, penalty will be 50% of total cost of the service.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	- 45 Visits per year. Includes physical, speech, occupational, and cognitive therapies.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	- <u>Preauthorization</u> may be required - if not obtained, penalty will be 50% of total cost of the service.
	<u>Skilled nursing care</u>	\$200 <u>copay</u> then 20% <u>coinsurance</u>	\$200 <u>copay</u> , then 20% after Tier 1 <u>deductible</u>	\$200 copay per day for the first 3 days, then 50% <u>coinsurance</u>	- 60 days per year - <u>Preauthorization</u> may be required - if not obtained, penalty will be 50% of total cost of the service.
	<u>Durable medical equipment</u>	50% after <u>deductible</u>	50% after Tier 1 <u>deductible</u>	50% after Tier 1 <u>deductible</u>	- Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	Inpatient: \$200 <u>copay</u> then 20% <u>coinsurance</u> Outpatient: 20% after <u>deductible</u>	Inpatient: \$200 <u>copay</u> per day for the first 3 days, then 40% after <u>deductible</u> Outpatient: 40% after <u>deductible</u>	Inpatient: \$200 <u>copay</u> per day for the first 3 days, then 50% after <u>deductible</u> Outpatient: 50% after <u>deductible</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 50% of 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
- Bariatric Surgery
- Dental Care (Adult & Child)
- 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 plan document.)**

- ABA Therapy
- Chiropractic Care – spinal manipulations are covered (20 visits per year)
- Cosmetic surgery (Requires prior auth., and only considered if due to bodily injury or illness and a functional impairment is present)
- Hearing Aids (Under age 18 if hearing aids are fitted and dispensed by a licensed audiologist or hearing aid specialist.)
- Infertility Treatment \$25,000 Lifetime max
- 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 is:

- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules.

**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:

- Your plan at 1-985-230-6532
- 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 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 1-866-4ASSIST (427-7478).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-4ASSIST (427-7478).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-4ASSIST (427-7478).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-4ASSIST (427-7478).

—————*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** \$1,500
- **Specialist coinsurance** 20%
- **Hospital (facility) copayment** \$200
- **Other** 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$2,410</b>

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

- **The plan's overall deductible** \$1,500
- **Specialist coinsurance** 20%
- **Hospital (facility) copayment** \$200
- **Other** 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$900
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,600</b>

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

- **The plan's overall deductible** \$1,500
- **Specialist coinsurance** 20%
- **Hospital (facility) copayment** \$200
- **Other** 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>