North Oaks Health System: PPO Plan

Coverage for: Individual +Family | **Plan Type: PPO**

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 coverage1-985-230-6532. 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 deductible?	Tier 1: **$250** Single/**$750** Family; Tier 2: **$3,000** Single/**$9,000** Family; Tier 3: **$5,000** Single/ **$15,000** 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 copayment 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: **$3,000** Single/**$6,000** Family; Tier 2: **$8,000** Single/**$16,000** 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 in 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-network Transplant, Non-Network Prescription Drugs, Non-network Specialty Drugs, amounts over allowed amount & non network immune effector cell therapy	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. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of Humana network providers. 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 **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 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	$15 copay/visit deductible does not apply	$40 copay/visit deductible does not apply	50% coinsurance	None
	Specialist visit	$25 copay/visit deductible does not apply	$70 copay/visit deductible does not apply	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 True Emergency	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	Non-emergency Out-of- Network benefit is: 50% coinsurance after Out- of - Network 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 not obtained, penalty will be 50% of the total cost of services.

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		Your cost if you use 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**	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com 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 $3,000 per covered person per year for drugs purchased at North Oaks Prescription Centers. $8,000 per covered per year for drugs purchased at Express Scripts Pharmacies.
	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	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.
	Compound Medications	35% coinsurance	45% coinsurance	Not covered	Mail order not available
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	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use 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 need immediate medical attention	Emergency room care True Emergency	$150 copay then 10% coinsurance	$150 copay then 10% coinsurance after tier 1 deductible	$150 copay then 10% coinsurance after tier 1 deductible	Out-of-Network for a non-emergency is a $150 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	$15 Copay/ visit deductible does not apply	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay then 10% after deductible	$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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	$40 copay/visit	50% coinsurance	Marriage Counseling Tier 1: $25 copay per visit & Tier 2: $70 copay per visit.
	Inpatient services	$200 copay then 10% coinsurance	$200 copay then 10% coinsurance 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	$25 copay / then 10% coinsurance	$70 copay / then 30% coinsurance	50% coinsurance	Office visit copay only applies to initial visit.
	Childbirth/delivery facility services	$200 copay then 10% after 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your cost if you use 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 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	Preauth is required. If you don't get preauth, benefits could be reduced by 50% of the total cost of the service.
	Habilitation services	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.
	Skilled nursing care	$200 copay then 10% coinsurance	$200 copay 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% after Tier 3 deductible	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 then 10% coinsurance after deductible Outpatient: 10% after deductible	Inpatient: $200 copay per day for the first 3 days, then 30% coinsurance after deductible Outpatient: 30% after deductible	Inpatient: $200 copay per day for the first 3 days, then 50% coinsurance 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)
- 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
- Bariatric surgery (limited to $20,000 per lifetime)
- Chiropractic Care – spinal manipulations are covered (30 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 (Coverage for hearing aids for children under the age of 18 if hearing aids are fitted and dispensed by licensed audiologist or hearing aid specialist.)
- Infertility Treatment $25,000 Lifetime Maximum
- Private Duty Nursing (Inpatient 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
- 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.
- 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.

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, kwiijigo 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	**$250**
Specialist copayment	**$25**
Hospital (facility) copayment	**$200**
Other	**10%**

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	$250
Copayments	$200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$470**

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

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) copayment	**$200**
Other	**10%**

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	$250
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,350**

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

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) copayment	**$200**
Other	**10%**

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	$250
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**