

North Oaks Health System: PPO 5000 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 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 deductible?	Tier 1: \$350 Single/ \$1,050 Family; Tier 2: \$1,250 Single/ \$3,750 Family; Tier 3: \$1,500 Single/ \$4,500 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 deductible?	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 <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 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 <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Tier 1: \$4,000 Single/ \$8,000 Family; Tier 2: \$5,000 Single/ \$10,000 Family; Tier 3: Unlimited Single / Unlimited 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 out-of-pocket limit?	<u>Premiums</u> , <u>Balance-billing</u> charges, Health care this <u>plan</u> doesn't cover, Penalties, Tier 3 <u>copays</u> , <u>Non-network</u> Transplant, <u>Non-Network</u> Prescription Drugs, <u>Non-network</u> <u>Specialty Drugs</u> & amounts over <u>allowed amount</u>	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 network provider?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of Humana <u>network providers</u> . For North Oaks In -Network providers, Call North Oaks at 1-985-230-6532.	This <u>plan</u> uses a <u>provider 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 referral to see a specialist?	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 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	\$20 <u>copay</u> /visit <u>deductible</u> does not apply	\$30 <u>copay</u> /visit <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$36 <u>copay</u> /visit <u>deductible</u> does not apply	\$60 <u>copay</u> /visit <u>deductible</u> does not apply	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	No charge	No charge	50% <u>coinsurance</u>	Non-emergency Out-of- Network benefit is: 50% <u>coinsurance</u> after Out- of - Network <u>deductible</u>
	-Inpatient and Independent Lab	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	-Outpatient Lab	\$10 <u>copay</u> /per test	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	-Emergency Room True Emergency	10% <u>coinsurance</u> after tier 1 <u>deductible</u>	10% <u>coinsurance</u> after tier 1 <u>deductible</u>	10% <u>coinsurance</u> after tier 1 <u>deductible</u>	
	<u>Imaging</u> (CT/PET scans, MRIs) -Clinic -Other than Clinic	No charge 10% <u>coinsurance</u>	30% <u>coinsurance</u> 30% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	- <u>Preauth</u> is required for Advanced Imaging. If not obtained, penalty will be 50% of the total cost of services.

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)	
		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 \$4,000 per covered person per year for drugs purchase In-Network. Out-of-Pocket is unlimited for Out-of-Network drug purchases. 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% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauth</u> is required. If you don’t get <u>preauth</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	

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	<u>Emergency room care</u> True Emergency	\$125 <u>copay</u> then 10% <u>coinsurance</u>	\$125 <u>copay</u> then 10% <u>coinsurance</u> after tier 1 <u>deductible</u>	\$125 <u>copay</u> then 10% <u>coinsurance</u> after tier 1 <u>deductible</u>	Out-of-Network for a non-emergency is a \$125 copay then 50% after Out-of-Network <u>deductible</u>
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% coinsurance after Tier 1 <u>deductible</u>	10% coinsurance after Tier 1 deductible	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	10% 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 10% after <u>deductible</u>	\$200 <u>copay</u> per day for the first 3 days, then 30% <u>coinsurance</u>	\$200 <u>copay</u> per day for the first 3 days, then 50% <u>coinsurance</u>	<u>Preauth</u> is required. If you don't get <u>preauth</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /visit	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	Marriage Counseling Tier 1: \$36 copay per visit & Tier 2: \$60 copay per visit.
	Inpatient services	\$200 <u>copay</u> then 10% <u>coinsurance</u>	\$200 <u>copay</u> then 10% <u>coinsurance</u> after tier 1 <u>deductible</u>	\$200 <u>copay</u> per day for the first 3 days, then 50% <u>coinsurance</u>	<u>Preauth</u> is required. If you don't get <u>preauth</u> , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Childbirth/delivery professional services	\$36 <u>copay</u> / then 10% <u>coinsurance</u>	\$60 copay / then 30% <u>coinsurance</u>	50% <u>coinsurance</u>	Office visit <u>copay</u> only applies to initial visit.
	Childbirth/delivery facility services	\$200 <u>copay</u> then 10% after <u>coinsurance</u>	\$200 <u>copay</u> per day for the first 3 days, then 30% <u>coinsurance</u>	\$200 <u>copay</u> per day for the first 3 days, then 50% <u>coinsurance</u>	<u>Preauth</u> is required. If you don't get <u>preauth</u> , 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	<u>Home health care</u>	10% <u>coinsurance</u>	10% coinsurance after Tier 1 <u>deductible</u>	50% <u>coinsurance</u>	<u>Preauth</u> is required. If you don't get <u>preauth</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauth</u> is required. If you don't get <u>preauth</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauth</u> is required. If you don't get <u>preauth</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Skilled nursing care</u>	\$200 <u>copay</u> then 10% <u>coinsurance</u>	\$200 <u>copay</u> then 10% after Tier 1 <u>deductible</u>	\$200 <u>copay</u> per day for the first 3 days, then 50% <u>coinsurance</u>	Coverage is limited to 60 days. <u>Preauth</u> is required. If you don't get <u>preauth</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% after Tier 1 <u>deductible</u>	50% <u>coinsurance</u>	<u>Preauth</u> is required. If you don't get <u>preauth</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Hospice services</u>	Inpatient: \$200 <u>copay</u> then 10% <u>coinsurance</u> after <u>deductible</u> Outpatient: 10% after <u>deductible</u>	Inpatient: \$200 <u>copay</u> per day for the first 3 days, then 30% <u>coinsurance</u> after <u>deductible</u> Outpatient: 30% after <u>deductible</u>	Inpatient: \$200 <u>copay</u> per day for the first 3 days, then 50% <u>coinsurance</u> after <u>deductible</u> Outpatient: 50% after <u>deductible</u>	<u>Preauth</u> is required. If you don't get <u>preauth</u> , 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
- Wigs, unless for chemotherapy, radiation and alopecia patients, limited to \$300 per lifetime
- Routine Hearing exams and testing
- Dental Care (Adult & Child)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Routine eye care (Adult & Child)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care – spinal manipulations are covered (30 visits per year)
- Bariatric surgery (limited to \$20,000 per lifetime)
- ABA Therapy
- 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.)
- Cosmetic surgery (requires prior auth., and only considered if due to bodily injury or illness and a functional impairment is present)
- 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, 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 **\$350**
- Specialist copayment **\$36**
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$200
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$430

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

- The plan's overall deductible **\$350**
- Specialist copayment **\$36**
- 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
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In this example, Joe would pay:

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

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

- The plan's overall deductible **\$350**
- Specialist copayment **\$36**
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$200
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700