




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, visit www.bcbsla.com or call 1-800-495-2583. 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 www.healthcare.gov/sbc-glossary or call 1-800-363-9150 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	EPO Providers: \$600 individual or \$1,200 family; <u>network providers</u> \$800 individual or \$1,600 family; for <u>out-of-network providers</u> \$800 individual or \$1,600 family	Generally, you must pay all of the costs from <u>providers</u> 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> and <u>Wellness</u> are 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the Common Medical Events chart for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	EPO Providers: \$2,500 individual or \$5,000 family; <u>network providers</u> \$2,750 individual or \$5,500 family; for <u>out-of-network providers</u> \$2,750 individual or \$5,500 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</u> Charges, and Health Care this <u>plan</u> doesn't cover.	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 www.bcbsla.com or call 1-800-495-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> 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 can see the specialist you choose without a referral .
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 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
		Employer Preferred Option Provider (You will pay the least)	Network Provider	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 <u>Copayment</u>	\$30 <u>Copayment</u>	30% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$35 <u>Copayment</u>	\$45 <u>Copayment</u>	30% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Other practitioner office visit</u>	\$35 <u>Copayment</u>	\$45 <u>Copayment</u>	30% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No Cost	No Cost	30% <u>Coinsurance</u> after <u>deductible</u>	None
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>Coinsurance</u> after <u>deductible</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	X-Rays, Lab Tests and Machine Tests performed within the office, clinic, or independent lab of a Network Provider that is subject to the Office Visit Copayment are covered at 100%.
	Imaging (CT/PET scans, MRIs)	10% <u>Coinsurance</u> after <u>deductible</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.

Questions: Call 1-800-363-9150

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Employer Preferred Option Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 1-800-334-8134 .	Tier 1	\$15 <u>Copayment</u> retail; \$30 <u>Copayment</u> mail order	\$15 <u>Copayment</u> retail; \$30 <u>Copayment</u> mail order	N/A	Retail: 34-day supply Mail Order: 90-day supply Maximum out of pocket amounts for prescription drugs are: \$5,150 Per Person/\$10,300 Per Family; Per Calendar Year.
	Tier 2	\$40 <u>Copayment</u> Retail; \$80 <u>Copayment</u> mail order	\$40 <u>Copayment</u> Retail; \$80 <u>Copayment</u> mail order	N/A	Retail: 34-day supply Mail Order: 90-day supply Maximum out of pocket amounts for prescription drugs are: \$5,150 Per Person/\$10,300 Per Family; Per Calendar Year.
	Tier 3	\$60 <u>Copayment</u> retail; \$120 <u>Copayment</u> mail order	\$60 <u>Copayment</u> retail; \$120 <u>Copayment</u> mail order	N/A	Retail: 34-day supply Mail Order: 90-day supply Maximum out of pocket amounts for prescription drugs are: \$5,150 Per Person/\$10,300 Per Family; Per Calendar Year.
	Tier 4	\$75 <u>Copayment</u> Retail; \$150 <u>Copayment</u> mail order	\$75 <u>Copayment</u> Retail; \$150 <u>Copayment</u> mail order	N/A	Retail: 34-day supply Mail Order: 90-day supply Maximum out of pocket amounts for prescription drugs are: \$5,150 Per Person/\$10,300 Per Family; Per Calendar Year. Specialty medications are limited to 30-day supply and must be ordered from the specialty pharmacy designated by this plan at 1-800-803-2523. Specialty medications require prior authorization and quantity limits or step therapy may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>Coinsurance</u> after <u>deductible</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	10% <u>Coinsurance</u>	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Employer Preferred Option Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
		after deductible	after deductible	after deductible	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	None
	<u>Emergency medical transportation</u>	Ground & Air: 10% <u>Coinsurance</u> after deductible	Ground & Air: 10% <u>Coinsurance</u> after deductible	Ground & Air: 10% <u>Coinsurance</u> after deductible	None
	<u>Urgent care</u>	\$40 <u>Copayment</u>	\$50 <u>Copayment</u>	30% <u>Coinsurance</u> after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	30% <u>Coinsurance</u> after deductible	Must obtain authorization. Failure to do so will result in a \$500 penalty and no benefit if not medically necessary.
	Physician/surgeon fees	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	30% <u>Coinsurance</u> after deductible	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Employer Preferred Option Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral outpatient services	Office Visits: \$35 <u>Copayment</u> ; All Other Services: 0% <u>Coinsurance</u> ; <u>deductible</u> waived	Office Visits: \$45 <u>Copayment</u> All Other Services: 0% <u>Coinsurance</u> ; <u>deductible</u> waived	30% <u>Coinsurance</u> after <u>deductible</u>	Authorization may be required.
	Mental/Behavioral inpatient services	10% <u>Coinsurance</u> after <u>deductible</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization. Failure to do so will result in a \$500 penalty and no benefit if not medically necessary.
	Substance use disorder outpatient services	Office Visits: \$35 <u>Copayment</u> ; All Other Services: 0% <u>Coinsurance</u> ; <u>deductible</u> waived	Office Visits: \$45 <u>Copayment</u> All Other Services: 0% <u>Coinsurance</u> ; <u>deductible</u> waived	30% <u>Coinsurance</u> after <u>deductible</u>	Authorization may be required.
	Substance use disorder inpatient services	10% <u>Coinsurance</u> after <u>deductible</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization. Failure to do so will result in a \$500 penalty and no benefit if not medically necessary.
If you are pregnant	Office visits	Initial Visit: \$35 <u>Copayment</u> All Other Services: 10% <u>Coinsurance</u> after <u>deductible</u>	Initial Visit: \$45 <u>Copayment</u> All Other Services: 10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	Dependent maternity is not covered under this Benefit Plan.
	Childbirth/delivery professional services	10% <u>Coinsurance</u> after <u>deductible</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	Authorization required if the mother's length of stay exceeds 48 hours following a vaginal delivery or 96 hours following a caesarean section.
	Childbirth/delivery facility services	10% <u>Coinsurance</u> after <u>deductible</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	
If you need help recovering or have	<u>Home health care</u>	10% <u>Coinsurance</u> after <u>deductible</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Employer Preferred Option Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
other special health needs	<u>Rehabilitation services</u>	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	30% <u>Coinsurance</u> after deductible	None
	<u>Habilitation services</u>	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	30% <u>Coinsurance</u> after deductible	None
	<u>Skilled nursing care</u>	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	30% <u>Coinsurance</u> after deductible	Must obtain authorization.
	<u>Durable medical equipment</u>	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	30% <u>Coinsurance</u> after deductible	Must obtain authorization (DME greater than \$1,000).
	<u>Hospice services</u>	10% <u>Coinsurance</u> after deductible	10% <u>Coinsurance</u> after deductible	30% <u>Coinsurance</u> after deductible	Must obtain authorization.
If your child needs dental or eye care	Children's eye exam	\$25 Copayment	\$30 Copayment	Not Covered	Limited to one (1) routine eye exam.
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> Bariatric Surgery Cosmetic Surgery Dental Care 	<ul style="list-style-type: none"> Hearing Aids (Adult) Infertility Treatment Long-Term Care 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Acupuncture Chiropractic Care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the United States 	<ul style="list-style-type: none"> Private-Duty Nursing (Inpatient) Routine Eye Care

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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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-800-495-2583

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-495-2583

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'1-800-495-2583

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

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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 \$800
- Specialist copayment \$45
- Hospital (facility) coinsurance 10%
- Other coinsurance 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 \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$60
Coinsurance	\$920
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,840

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

- The plan's overall deductible \$800
- Specialist copayment \$45
- Hospital (facility) coinsurance 10%
- Other coinsurance 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 \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$140
Copayments	\$1,520
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,720

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

- The plan's overall deductible \$800
- Specialist copayment \$45
- Hospital (facility) coinsurance 10%
- Other coinsurance 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 \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$100
Coinsurance	\$160
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,060

