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 deductible?	EPO Providers: $750 individual or $1,500 family; network providers $1,000 individual or $2,000 family; for out-of-network providers $1,250 individual or $3,750 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 and Wellness are 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 **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 don't have to meet **deductibles** for specific services, but see the Common Medical Events chart for other costs for services this **plan** covers.
What is the out-of-pocket limit for this plan?	EPO Providers: $3,000 individual or $6,000 family; network providers $3,500 individual or $7,000 family; for out-of-network providers $5,000 individual or $15,000 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, and Health Care this plan doesn't cover.	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.bcbsla.com** or call **1-800-495-2583** for a list of **network providers**.	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 can see the **specialist** you choose without a **referral**.

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	$30 Copayment	$40 Copayment	30% Coinsurance after deductible	None
	Specialist visit	$45 Copayment	$55 Copayment	30% Coinsurance after deductible	None
	Other practitioner office visit	$45 Copayment	$55 Copayment	30% Coinsurance after deductible	None
	Preventive care/screening/ immunization	No Cost	No Cost	30% Coinsurance after deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	No cost, if in office 10% Coinsurance after deductible	No cost, if in office 10% Coinsurance after deductible	30% Coinsurance after deductible	No Cost, if performed in an office, clinic or independent lab of a Network copay Provider.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization.

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 at http://www.Optumrx.com/myCatamaranrx	Generic Drugs: Tier 1	$15 Copayment retail; $45 Copayment mail order	$15 Copayment retail; $45 Copayment mail order	n/a	Mail Order: 90-day supply The Rx OOP is $4,100 (2x) Family
	Preferred Brand Drugs: Tier 2	$40 Copayment Retail; $120 Copayment mail order	$40 Copayment Retail; $120 Copayment mail order	n/a	Mail Order: 90-day supply The Rx OOP is $4,100 (2x) Family
	Non-preferred Brand Drugs: Tier 3	$75 Copayment retail; $225 Copayment mail order	$75 Copayment retail; $225 Copayment mail order	n/a	Mail Order: 90-day supply The Rx OOP is $4,100 (2x) Family
	Specialty Drugs: Tier 4	Generic/Preferred Brand/Non-Preferred Brand Copays apply	Generic/Preferred Brand/Non-Preferred Brand Copays apply	n/a	The Rx OOP is $4,100 (2x) Family Specialty medications must be ordered through Briova Rx at 1-800-850-9122. Specialty drugs are limited to a 31-day supply and may require prior authorization. Please note that manufacturer copay assistance programs will not accumulate toward a patient's prescription deductible or out of pocket maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 Copayment	$150 Copayment	30% Coinsurance after deductible	None
	Physician/surgeon fees	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	None

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 immediate medical attention	Emergency room care	$150 Copayment	$150 Copayment	$150 Copayment	None
	Emergency medical transportation	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	None
	Urgent care	$45 Copayment	$55 Copayment	30% Coinsurance after deductible	None
If you have a hospital stay	Facility Fee (e.g., hospital room)	$250 Copayment per inpatient stay	$250 Copayment per inpatient stay	30% Coinsurance after deductible	None
	Physician/surgeon fees	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral outpatient services	Office Visits: $45 Copayment;	Office Visits: $55 Copayment	30% Coinsurance after deductible	Authorization may be required.
	Mental/Behavioral inpatient services	$250 Copayment per inpatient stay	$250 Copayment per inpatient stay	30% Coinsurance after deductible	Must obtain authorization.
	Substance use disorder outpatient services	Office Visits: $45 Copayment;	Office Visits: $55 Copayment	30% Coinsurance after deductible	Authorization may be required.
	Substance use disorder inpatient services	$250 Copayment per inpatient stay	$250 Copayment per inpatient stay	30% Coinsurance after deductible	Must obtain authorization.

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 are pregnant	Office visits	$30 Copayment per pregnancy for Employee or Dependent Spouse; $30 Copayment per visit for Dependent Child of an Employee	$40 Copayment per pregnancy for Employee or Dependent Spouse; $40 Copayment per visit for Dependent Child of an Employee	30% Coinsurance after deductible	Coverage for a pregnant Dependent Child of an Employee is limited to prenatal services performed in an office visit setting only and does not cover postnatal care.
	Childbirth/delivery professional services	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	Authorization required if the mother's length of stay exceeds 48 hours following a vaginal delivery or 96 hours following a caesarean section. Coverage for a pregnant Dependent Child of an Employee is limited and does not include the Delivery or any inpatient services.
	Childbirth/delivery facility services	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	

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 help recovering or have other special health needs	Home health care	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization. Limited to 150 visits per benefit period.
	Rehabilitation services	$45 Copayment per visit	$55 Copayment per visit	30% Coinsurance after deductible	Chiropractic visits and services may vary.
	Habilitation services	$45 Copayment per visit	$55 Copayment per visit	30% Coinsurance after deductible	None
	Skilled nursing care	$250 Copayment per inpatient stay	$250 Copayment per inpatient stay	30% Coinsurance after deductible	Must obtain authorization.
	Durable medical equipment	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	Authorization may be required.
	Hospice services	10% Coinsurance after deductible	10% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization.
If your child needs dental or eye care	Children's eye exam	$30 Copayment	$40 Copayment	Not Covered	Limited to one every 12 months
	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 excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Glasses (Adult/Child)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing (Outpatient)
- 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.)

- Acupuncture
- Chiropractic Care
- Routine Eye Care

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, kwiijigo holne'1-800-495-2583

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	$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**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposici6n servicios lingufsticos gratuitos. De necesitarlos, por favor, llame al numero del Servicio de Atenci6n al Cliente que aparece en el reverso de su tarjeta de identificaci6n. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si necessaire, veuillez appeler le numero du Service clientele figurant au verso de votre carte d'identification. Si vous souffrez d'une deficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

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Kostenlose Sprachdienste stehen zur Verfugung. Falls Sie diese benotigen, rufen Sie bitte die Kundendienstnummer auf der Ruckseite Ihrer ID-Karte an. Horbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

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