




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](http://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](http://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> ?	For <u>network providers</u> \$2,000 individual or \$6,000 family; for <u>out-of-network providers</u> \$4,000 individual or \$12,000 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 <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 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> ?	For <u>network providers</u> \$6,250 individual / \$12,500 family; for <u>out-of-network providers</u> \$12,500 individual / \$25,000 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 <a href="http://www.bcbsla.com">www.bcbsla.com</a> 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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$40 <u>Copayment</u>	50% <u>Coinsurance</u> after <u>deductible</u>	If you have a copayment plan, the PCP copayment may be reduced or waived when services are rendered by a Quality Blue Primary Care Provider (QBPC).
	<u>Specialist</u> visit	\$55 <u>Copayment</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Other practitioner office visit</u>	\$55 <u>Copayment</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/Immunization</u>	No Cost	50% <u>Coinsurance</u> ; <u>deductible waived</u>	None
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsla.com">http://www.bcbsla.com</a>	Tier 1	\$7 <u>Copayment</u> retail; \$21 <u>Copayment</u> mail order	\$7 <u>Copayment</u> retail; \$21 <u>Copayment</u> mail order	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program.
	Tier 2	\$30 <u>Copayment</u> retail; \$90 <u>Copayment</u> mail order	\$30 <u>Copayment</u> retail; \$90 <u>Copayment</u> mail order	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3	\$70 <u>Copayment</u> retail; \$210 <u>Copayment</u> mail order	\$70 <u>Copayment</u> retail; \$210 <u>Copayment</u> mail order	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4	10% <u>Coinsurance</u> up to \$150 maximum	10% <u>Coinsurance</u> up to \$150 maximum	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	30% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	None

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bcbsla.com](http://www.bcbsla.com) or [www.healthcare.gov](http://www.healthcare.gov) or call 1-800-363-9150 to request a copy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	Ground: 30% <u>Coinsurance</u> after <u>deductible</u> Air: 30% <u>Coinsurance</u> after <u>deductible</u>	Ground: 50% <u>Coinsurance</u> after <u>deductible</u> Air: 30% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	\$55 <u>Copayment</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization
	Physician/surgeon fees	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Mental/Behavioral outpatient services	Office Visits: \$40 <u>Copayment</u> ; All Other Services: 30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Authorization may be required.
	Mental/Behavioral inpatient services	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
	Substance use disorder outpatient services	Office Visits: \$40 <u>Copayment</u> ; All Other Services: 30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Authorization may be required.
	Substance use disorder inpatient services	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
<b>If you are pregnant</b>	Office visits	\$40 <u>Copayment</u>	50% <u>Coinsurance</u> after <u>deductible</u>	There is coverage for Pregnancy of a Dependent child.
	Childbirth/delivery professional services	30% <u>Coinsurance</u> after <u>deductible</u>	50% <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	30% <u>Coinsurance</u> after <u>deductible</u>	50% <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.
<b>If you need help</b>	<u>Home health care</u>	30% <u>Coinsurance</u> after	50% <u>Coinsurance</u> after	Must obtain authorization.

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bcbsla.com](http://www.bcbsla.com) or [www.healthcare.gov](http://www.healthcare.gov) or call 1-800-363-9150 to request a copy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
recovering or have other special health needs		<u>deductible</u>	<u>deductible</u>	
	<u>Rehabilitation services</u>	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Habilitation services</u>	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Skilled nursing care</u>	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
	<u>Durable medical equipment</u>	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Authorization may be required.
	<u>Hospice services</u>	30% <u>Coinsurance</u> after <u>deductible</u>	50% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	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.)

<ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Infertility Treatment</li> <li>Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>Routine Eye Care</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>
--	---	---

##### 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"> <li>Acupuncture</li> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the United States</li> </ul>	<ul style="list-style-type: none"> <li>Private-Duty Nursing (Outpatient)</li> </ul>
--	---	---

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bcbsla.com](http://www.bcbsla.com) or [www.healthcare.gov](http://www.healthcare.gov) or call 1-800-363-9150 to request a copy.

**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](http://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](http://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](http://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.*

---

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bcbsla.com](http://www.bcbsla.com) or [www.healthcare.gov](http://www.healthcare.gov) or call 1-800-363-9150 to request a copy.

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 \$2,000
- Specialist copayment \$55
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$2,720
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,790</b>

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

- The plan's overall deductible \$2,000
- Specialist copayment \$55
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$10
Copayments	\$1,410
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,480</b>

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

- The plan's overall deductible \$2,000
- Specialist copayment \$55
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$120
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,210</b>