




**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb) by calling 1-800-392-4089.

| Important Questions                                       | Answers  | Why this Matters:   |
|---|--|---|
| What is the overall <u>deductible</u> ?                   | <b>Network &amp; Non-Network Providers:</b> \$300 Person per Calendar Year; Family Maximum of 3 Individual Deductibles per Calendar Year   | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the Common Medical Event chart for how much you pay for covered services after you meet the <b>deductible</b> .   |
| Are there other <u>deductibles</u> for specific services? | Yes. \$150 Emergency Room Deductible (waived if admitted)  | You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.   |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes. <b>In-Network Providers:</b> Employee Only-\$1,300: Employee Plus One (Spouse or Child)-\$2,600: Family of 3-\$3,900: Family of 4-\$4,900: Family of 5-\$5,900: Family of 6-\$6,900; Family of 7-\$7,900: Family of 8-\$8,900: Family of 9-\$9,900: Family of 10-\$10,900: Family of 11-\$11,900: Family of 12 or More-\$12,700. <b>Non-Network Providers:</b> Employee Only - \$3,300: Employee Plus One (Spouse or Child)-\$6,600: Family of 3-\$9,900: Family of 4 or More-\$12,700. | The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.  |
| What is not included in the <u>out-of-pocket limit</u> ?  | Premiums, Member Cost Share, Balance Billed Charges, and Health Care this plan doesn't cover.  | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .  |
| Is there an overall annual limit on what the plan pays?   | No.  | The Common Medical Event chart describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.  |
| Does this plan use a <u>network of providers</u> ?        | Yes. For a full listing of network providers, see <a href="http://www.bcbsla.com/ogb">www.bcbsla.com/ogb</a> or call 1-800-392-4089.   | If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the Common Medical Event chart for how this plan pays different kinds of <b>providers</b> . |

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|  |  |   |
|--|--|---|
| <b>Do I need a referral to see a specialist?</b>   | No. You don't need a referral to see a specialist. | You can see the <b>specialist</b> you choose without permission from this plan.   |
| <b>Are there services this plan doesn't cover?</b> | Yes.   | Some of the services this plan doesn't cover are listed in Excluded Services & Other Covered Services. See your policy or plan document for additional information about <b>excluded services</b> . |

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
  - **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
  - The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
  - This plan may encourage you to use Preferred **providers** by waiving or charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event   | Services You May Need                            | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|--|--|---|---|--------------------------|
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | 10% coinsurance after deductible            | 30% coinsurance after deductible                | None                     |
|  | Specialist visit                                 | 10% coinsurance after deductible            | 30% coinsurance after deductible                | None                     |
|  | Other practitioner office visit                  | 10% coinsurance after deductible            | 30% coinsurance after deductible                | None                     |
|  | Preventive care/screening                        | No Cost                                     | 30% coinsurance after deductible                | None                     |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)              | 10% coinsurance after deductible            | 30% coinsurance after deductible                | None                     |
|  | Imaging (CT/PET scans, MRIs)                     | 10% coinsurance after deductible            | 30% coinsurance after deductible                | None                     |

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# STATE OF LOUISIANA OFFICE OF GROUP BENEFITS

Coverage Period: 01/01/2014-09/29/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Non-Medicare Retirees | Plan Type: PPO**

| Common Medical Event  | Services You May Need   | Your Cost If You Use an In-network Provider   | Your Cost If You Use an Out-of-network Provider   | Limitations & Exceptions  |
|---|---|---|---|---|
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available by calling OGB Customer Service at (800)272-8451 | Generic Drugs (\$50 Maximum per 31 day prescription; up to the \$1,200 Out-of-Pocket Maximum per Person per Plan Year)    | \$0 after Maximum Out-of-Pocket is met  | 50% coinsurance –In State<br>80% coinsurance-Out of State                                     | Appetite suppressant drugs; Dietary supplements; Topical forms of Minoxidil; Retin-A dispensed for a Covered Person over age 26; Amphetamines dispensed for diagnoses other than Attention Deficit Disorder or Narcolepsy; Nutritional or parenteral therapy; Vitamins and minerals; Drugs available over the counter; Serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting; Drugs prescribed for treatment of impotence, except following the surgical removal of the prostate gland; Glucometers. |
|   | Brand Name Drugs (\$50 Maximum per 31 day prescription; up to the \$1,200 Out-of-Pocket Maximum per Person per Plan Year) | \$15 after Maximum Out-of-Pocket is met   | 50% coinsurance –In State<br>80% coinsurance-Out of State                                     |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)  | 10% coinsurance after deductible  | 30% coinsurance after deductible  | None  |
|   | Physician/surgeon fees  | 10% coinsurance after deductible  | 30% coinsurance after deductible  | None  |
| <b>If you need immediate medical attention</b>  | Emergency room services   | Facility - \$150 separate deductible; Non-Facility Charges – 10% coinsurance after deductible | Facility - \$150 separate deductible; Non-Facility Charges – 10% coinsurance after deductible | Facility deductible waived if admitted  |
|   | Emergency medical transportation  | 10% coinsurance after deductible  | 30% coinsurance after deductible  | None  |
|   | Urgent care   | 10% coinsurance after deductible  | 30% coinsurance after deductible  | None  |

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Coverage Period: 01/01/2014-09/29/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Non-Medicare Retirees | Plan Type: PPO**

| Common Medical Event  | Services You May Need                        | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider  | Limitations & Exceptions   |
|---|--|---|--|--|
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)           | 10% coinsurance after deductible            | \$50 copayment per day; Maximum of 5 days per admission; then 30% coinsurance after deductible | Must obtain authorization.   |
|   | Physician/surgeon fee                        | 10% coinsurance after deductible            | 30% coinsurance after deductible   | None   |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | 10% coinsurance after deductible            | 30% coinsurance after deductible   | None   |
|   | Mental/Behavioral health inpatient services  | 10% coinsurance after deductible            | 30% coinsurance after deductible   | Must obtain authorization.   |
|   | Substance use disorder outpatient services   | 10% coinsurance after deductible            | 30% coinsurance after deductible   | None   |
|   | Substance use disorder inpatient services    | 10% coinsurance after deductible            | 30% coinsurance after deductible   | Must obtain authorization.   |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | 10% coinsurance after deductible            | 30% coinsurance after deductible   | None   |
|   | Delivery and all inpatient services          | 10% coinsurance after deductible            | \$50 copayment per day; Maximum of 5 days per admission; then 30% coinsurance after deductible | Authorization may be required if the mother's length of stay exceeds 48 or 96 hours following a vaginal or caesarean delivery, respectively. |

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Coverage Period: 01/01/2014-09/29/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Non-Medicare Retirees | Plan Type: PPO**

| Common Medical Event  | Services You May Need                         | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions  |
|---|---|---|---|---|
| <b>If you need help recovering or have other special health needs</b> | Home health care                              | 10% coinsurance after deductible            | 30% coinsurance after deductible                | None  |
|   | Rehabilitation services                       | 10% coinsurance after deductible            | 30% coinsurance after deductible                | Speech Therapy - Must obtain authorization; services limited to 26 visits per year.<br><br>Physical & Occupational Therapy – Must obtain Authorization for additional visits over the limit of 50 visits combined per year. |
|   | Habilitation services                         | 10% coinsurance after deductible            | 30% coinsurance after deductible                | Speech Therapy - Must obtain authorization; services limited to 26 visits per year.<br><br>Physical & Occupational Therapy – Must obtain Authorization for additional visits over the limit of 50 visits combined per year. |
|   | Skilled nursing care                          | 10% coinsurance after deductible            | 30% coinsurance after deductible                | Must obtain authorization.  |
|   | Durable medical equipment                     | 10% coinsurance after deductible            | 30% coinsurance after deductible                | None  |
|   | Hospice service                               | 20% coinsurance after deductible            | 30% coinsurance after deductible                | None  |
|   | <b>If your child needs dental or eye care</b> | Eye exam                                    | Routine – No Cost                               | Routine - 30% coinsurance after deductible  |
| Glasses   |   | Frames – Maximum Benefit of \$50            | Frames - Maximum Benefit of \$50                | Purchased within 6 months following cataract surgery  |
| Dental check-up   |   | Not Covered                                 | Not Covered                                     | Not Covered   |

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids (Adult)
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care
- Routine Foot Care (except for Diabetes)
- Weight Loss Programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic Care
- Non-emergency care when traveling outside the United States

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-392-4089. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blue Cross and BlueShield of Louisiana at 1-800-599-2583 or [www.bcbsla.com](http://www.bcbsla.com) OR the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,371
- Patient pays \$1,169

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Inpatient Medications      | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$300          |
| Co-pays              | \$23           |
| Coinsurance          | \$696          |
| Limits or exclusions | \$150          |
| <b>Total</b>         | <b>\$1,169</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,021
- Patient pays \$1,379

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits                  | \$250          |
| Procedures                     | \$450          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$300          |
| Co-pays              | \$886          |
| Coinsurance          | \$114          |
| Limits or exclusions | \$79           |
| <b>Total</b>         | <b>\$1,379</b> |

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance.

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