Office of Group Benefits

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Active Employees
Plan Type: HMO

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** or by calling **1-800-392-4089**.

Important Questions	Answers	Why this matters:
What is the overall deductible?	**$0 Individual/Family – Network Preferred Care Providers;** **$1,000 Individual/$3,000 Family Non-Network All Other Providers** **Does not apply to preventive care**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	**No**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**$1,000 Individual/$3,000 Family – Network Preferred Care Providers;** **$3,000 Individual/$9,000 Family- Non-Network All Other Providers**	The **out-of-pocket limit** 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 out–of–pocket limit?	**Covered Expenses for Organ Transplants**	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes**	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Event chart for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**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 **excluded services**.

Questions: Call 1-800-**392-4089** or visit us at **www.bcbsla.com/ogb** .

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** or www.healthcare.gov or call 1-800-392-4089 to request a copy.

Print Date: 10/02/12

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 **network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$15**	**30%**	
	Specialist visit	**$25**	**30%**	
	Other practitioner office visit	**$25**	**30%**	
	Preventive	**$0**	**30%**	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.catalystrx.com	Generic or Brand	**$50 maximum per 31 day prescription, up to the Maximum Out Of Pocket of $1,200 Per Person Per Plan Year**	**50% - In State** **80% - Out of State**	
	Generic	**$0, After Out of Pocket Maximum is Met**		
	Brand	**$15, After Out of Pocket Maximum is Met**		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$100 Copayment**	**30%**	
	Physician/surgeon fees	**$0 Copayment**	**30%**	

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	**$100 Copayment per day, maximum of $300 per admission**	**30%**	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$15 Copayment**	**30%**	
	Mental/Behavioral health inpatient services	**$100 Copayment per day, maximum of $300 per admission**	**30%**	
	Substance use disorder outpatient services	**$15 Copayment**	**30%**	
	Substance use disorder inpatient services	**$100 Copayment per day, maximum of $300 per admission**	**30%**	

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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Chiropractic care	• Hearing aids – under 18 years, Maximum $1,400

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 or plan sponsor at 800-272-8451 and TTY/TTD 800-259-6771. 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 , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov ."

a. Office of Group Benefits - 800-272-8451 and TTY/TTD 800-259-6771

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: 1-800-392-4089

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

Language Access Services:

You may be eligible to obtain assistance with this document in one of the following non-English languages.

Spanish (Español): Para obtener asistencia en Español, llame al (800)392-4089.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800)392-4089.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**(800)392-4089.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800)392-4089.

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

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** $7,052
- **Patient pays** $488

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$338
Co-insurance	$0
Limits or exclusions	$150
Total	**$488**

Managing Type 2 Diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $2,417
- **Patient pays** $1,683

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$0
Co-pays	$1,350
Co-insurance	$254
Limits or exclusions	$79
Total	**$1,683**

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**, **co-payments**, and **co-insurance** 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 **co-payments**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help pay out-of-pocket expenses.