




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/ogb](http://www.bcbsla.com/ogb) or call 1-800-392-4089. 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 1-800-392-4089 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <u>deductible</u> ?                             | For <u>network providers</u> Employee: \$0; Employee + 1: \$0 or \$0 family; for <u>out-of-network providers</u> No Coverage             | 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> Employee: \$1,000; Employee + 1: \$2,000 or \$3,000 family; for <u>out-of-network providers</u> No Coverage | 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/ogb">www.bcbsla.com/ogb</a> or call 1-800-392-4089 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | \$25 <u>Copayment</u> per visit   | No Coverage  | None   |
|  | <u>Specialist</u> visit                          | \$50 <u>Copayment</u> per visit   | No Coverage  | None   |
|  | <u>Other practitioner office visit</u>           | \$25 <u>Copayment</u> per visit   | No Coverage  | None   |
|  | <u>Preventive care/screening/immunization</u>    | No Cost   | No Coverage  | Age and/or time restrictions apply                     |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)       | Office, Free Standing Independent Diagnostic Testing Facility, or Contracted Reference Lab: 0% <u>Coinsurance</u><br>Outpatient Hospital: 0% <u>Coinsurance</u> | No Coverage  | None   |
|  | Imaging (CT/PET scans, MRIs)                     | \$50 <u>Copayment</u> per visit   | No Coverage  | Must obtain authorization.                             |

Questions: Call 1-800-392-4089

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| Common Medical Event  | Services You May Need   | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|---|---|---|---|---|
|   |   | Network Provider<br>(You will pay the least)                                      | Out-of-Network Provider<br>(You will pay the most)                                |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsla.com/ogb">http://www.bcbsla.com/ogb</a> or by calling 1-877-417-8952. | Generic Drugs (50% up to \$30 Maximum per 31 day prescription, up to the \$1,500 Out-of-Pocket Threshold per Person per Benefit Period)       | \$0 after Out-of-Pocket Threshold is met  |   | Appetite suppressant drugs; Dietary supplements; Topical forms of Minoxidil; Nutritional or parenteral therapy; Vitamins and minerals, except as required by law; Drugs available over the counter; medical foods; bulk chemicals; any federal legend drug with an over the counter equivalent available<br><br>Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM. |
|   | Preferred Drugs (50% up to \$55 Maximum per 31 day prescription, up to the \$1,500 Out-of-Pocket Threshold per Person per Benefit Period)     | \$20 after Out-of-Pocket Threshold is met   |   |   |
|   | Non-Preferred Drugs (65% up to \$80 Maximum per 31 day prescription, up to the \$1,500 Out-of-Pocket Threshold per Person per Benefit Period) | \$40 after Out-of-Pocket Threshold is met   |   |   |
|   | Specialty Drugs (50% up to \$80 Maximum per 31 day prescription up to the \$1,500 Out-of-Pocket Threshold per Person per Plan Year)           | \$40 after Out-of-Pocket Threshold is met   |   |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)  | \$100 <u>Copayment</u> per visit  | No Coverage   | None  |
|   | Physician/surgeon fees  | 0% <u>Coinsurance</u>   | No Coverage   | None  |
| <b>If you need immediate medical attention</b>  | <u>Emergency room care</u>  | Facility - \$150 <u>Copayment</u><br>Non-Facility Charges – 0% <u>Coinsurance</u> | Facility - \$150 <u>Copayment</u><br>Non-Facility Charges – 0% <u>Coinsurance</u> | Facility copayment waived if admitted to the same facility  |
|   | <u>Emergency medical transportation</u>   | Ground-\$50 <u>Copayment</u> per trip; Air-\$250 <u>Copayment</u> per trip        | Ground-\$50 <u>Copayment</u> per trip; Air-\$250 <u>Copayment</u> per trip        | Must obtain prior authorization for Non-Emergency Air Ambulance.  |
|   | <u>Urgent care</u>  | \$50 <u>Copayment</u> per visit   | No Coverage   | None  |

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| Common Medical Event   | Services You May Need                      | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|--|---|--|---|
|  |  | Network Provider<br>(You will pay the least)                            | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)         | \$100 <u>Copayment</u> per day; maximum of \$300 per admission          | No Coverage  | Must obtain authorization.  |
|  | Physician/surgeon fees                     | 0% <u>Coinsurance</u>   | No Coverage  | None  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Mental/Behavioral outpatient services      | \$25 <u>Copayment</u> per visit   | No Coverage  | Must obtain authorization for Intensive Outpatient Programs, Partial Hospitalization Programs, and services performed at Residential Treatment Centers. |
|  | Mental/Behavioral inpatient services       | \$100 <u>Copayment</u> per day; maximum of \$300 per admission          | No Coverage  | Must obtain authorization.  |
|  | Substance use disorder outpatient services | \$25 <u>Copayment</u> per visit   | No Coverage  | Must obtain authorization for Intensive Outpatient Programs, Partial Hospitalization Programs, and services performed at Residential Treatment Centers. |
|  | Substance use disorder inpatient services  | \$100 <u>Copayment</u> per day; maximum of \$300 per admission          | No Coverage  | Must obtain authorization.  |
| <b>If you are pregnant</b>   | Office visits                              | \$90 <u>Copayment</u> per pregnancy                                     | No Coverage  | None  |
|  | Childbirth/delivery professional services  | \$100 <u>Copayment</u> per day; maximum of \$300 per admission          | No Coverage  | 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      | \$100 <u>Copayment</u> per day; maximum of \$300 per admission          | No Coverage  |   |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                    | 0% <u>Coinsurance</u>   | No Coverage  | Must obtain authorization. Services limited to 60 visits per Benefit Period.  |
|  | <u>Rehabilitation services</u>             | \$25 <u>Copayment</u> per visit regardless of provider type or location | No Coverage  | Physical & Occupational Therapy – Services limited to 50 visits combined per Benefit Period. Must obtain Authorization for additional visits.           |
|  | <u>Habilitation services</u>               | \$25 <u>Copayment</u> per visit   | No Coverage  | Physical & Occupational Therapy – Services  |

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| Common Medical Event                          | Services You May Need            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|--|--|--|
|   |                                  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
|   |                                  | regardless of provider type or location  |  | limited to 50 visits combined per Benefit Period. Must obtain Authorization for additional visits.             |
|   | <u>Skilled nursing care</u>      | \$100 <u>Copayment</u> per day; maximum of \$300 per admission   | No Coverage  | Must obtain authorization. Services limited to 90 days per Benefit Period.                                     |
|   | <u>Durable medical equipment</u> | 20% <u>Coinsurance</u> of first \$5,000 Allowable per Benefit Period; 0% <u>Coinsurance</u> of Allowable in excess of \$5,000 per Benefit Period | No Coverage  | Must obtain authorization for durable medical equipment, orthotic devices, and prosthetics greater than \$300. |
|   | <u>Hospice services</u>          | 0% <u>Coinsurance</u>  | No Coverage  | Must obtain authorization. Services limited to 180 days per Benefit Period.                                    |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | No Coverage  | No Coverage  | Not Covered  |
|   | Children's glasses               | No Coverage  | No Coverage  | Not Covered  |
|   | Children's dental check-up       | No Coverage  | No Coverage  | Not Covered  |

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## 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.)

- Cosmetic Surgery
- Hearing Aids (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing
- Routine Eye Care
- Routine Foot Care (except for Diabetes)
- Weight Loss Programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care (Some restrictions apply)
- Dental Care (Coverage is only available for Oral Surgery for Impacted Teeth)
- Glasses - Frames limited to a maximum benefit of \$50. Must be purchased within 6 months following cataract surgery. Services are available for all members.

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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](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).

**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

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*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 \$0
- Specialist copayment \$50
- Hospital (facility) copayment \$100
- Other coinsurance 0%

**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                       | \$0          |
| Copayments                        | \$290        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$350</b> |

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

- The plan's overall deductible \$0
- Specialist copayment \$50
- Hospital (facility) copayment \$100
- Other coinsurance 0%

**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                       | \$0            |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$1,060</b> |

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

- The plan's overall deductible \$0
- Specialist copayment \$50
- Hospital (facility) copayment \$100
- Other coinsurance 0%

**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                       | \$0          |
| Copayments                        | \$380        |
| Coinsurance                       | \$50         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$430</b> |