ACADIANA MANAGEMENT GROUP, LLC

101 LA RUE FRANCE, SUITE 500
LAFAYETTE, LA 70508

Re: 78548ERC

**Here is your Summary of Benefits and Coverage**

We are committed to giving our customers an exceptional experience. Because we do our best to keep you informed, we've enclosed your *Summary of Benefits and Coverage.*

**What is a *Summary of Benefits and Coverage*?**
The *Summary of Benefits and Coverage* provides an overview of what your policy covers and outlines your benefits under your health insurance plan.

**Why am I receiving it?**
We sent you the *Summary* because the U.S. departments of Health and Human Services, Labor and the Treasury require health insurance issuers to provide this form when providing health insurance. If there are any material changes to your coverage during the year, you may receive a new Summary.

**What is a *Uniform Glossary* and where can I find it?**
A *Uniform Glossary* lists commonly used health coverage and medical terms that explain your health insurance coverage. To help you find those defined terms, we highlight many of them in blue in your *Summary*. If you find an unfamiliar term when you read your *Summary*, just go to the *Uniform Glossary* for an explanation. You can find the Uniform Glossary at www.bcbsla.com/reform.

As always, your satisfaction is our top priority. Thank you for allowing us to serve you.

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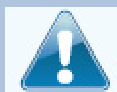
**If you have any questions? Just contact your producer or one of our Customer Service representatives toll free at 1-800-599-2583.**



**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** or by calling **1-800-495-2583**.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the **overall deductible**? | For in-network providers: **$2,000** Individual / **$6,000** Family For out-of-network providers: **$4,000** Individual / **$12,000** Family | You must pay all the costs up to the **deductible** amount before this health insurance 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 section 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 Common Medical Event section chart for other costs for services this plan covers. |
| Is there an **out-of-pocket limit** on my expenses? | Yes. For in-network providers: **$6,250** Individual / **$12,500** Family For out-of-network providers: **$12,500** Individual / **$25,000** Family | 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**? | Premiums, Balance Billed 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**. |
| Is there an overall annual limit on what the insurer pays? | No Maximum Individual/No Maximum Family | The Common Medical Event section chart describes any limits on what the insurer will pay for *specific* covered services, such as office visits. |
| Does this plan use a **network** of **providers**? | Yes. See **www.bcbsla.com or call 1-800-495-2583** for a list of participating providers. | 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 terms in-network, **preferred** or participating for **providers** in their **network**. See the Common Medical Event section chart for how this plan pays different kinds of **providers**. |
| Do I need a referral to see a **specialist**? | No. You don't need a referral to see a specialist. | 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 the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**. |

- **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 $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you visit a health care **provider's** office or clinic | Primary care visit to treat an injury or illness | $40 Copayment | 50% Coinsurance after deductible | 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). |
| | Specialist Visit | $55 Copayment | 50% Coinsurance after deductible | None |
| | Other practitioner office visit | $40 Copayment | 50% Coinsurance after deductible | None |
| | Preventive care/screening/immunization | No charge | 50% Coinsurance | Prostate Cancer Screening –One (1) digital rectal exam per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. One (1) prostate-specific antigen (PSA) test per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. A second visit shall be permitted for follow-up treatment within sixty (60) days after the first visit if related to a condition diagnosed or treated during the visit and recommended by a Physician. Colorectal Cancer Screening Fecal |

| | | | | |
|---|---|---|---|---|
| | | | | occult blood test: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Flexible sigmoidoscopy: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Colonoscopy: One (1) every ten (10) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Abdominal Aortic Aneurysm Screening: One per Benefit Period for Men ages 65-75; Mammography Examination - One (1) every twelve (12) months; Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; Routine Pap Smear - One (1) per Benefit Period; Autism Screening: Ages 1-2; Developmental Screening: Ages 0-3; Hearing Screening: One per Benefit Period for Children Ages 0-21; Lead Screening: One per Benefit Period for Ages 0-6; Tuberculosis Screening: One per Benefit Period for Ages 0-21; Vision Screening: One per Benefit Period for Ages 0-21; |
| If you have a test | Diagnostic Test (x-ray, blood test) | 30% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| | Imaging (CT/PET scans, MRIs) | 30% Coinsurance after deductible | 50% Coinsurance after deductible | Must obtain authorization. |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you need drugs to treat your illness or condition<br><br>More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-4tier-formulary2017 | Tier 1 | $15 Copayment | $15 Copayment | Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. If the Member chooses to purchase a Brand-Name Prescription for which an approved Generic is available, the Member will pay the Value Drug Copayment, plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount. |
| | Tier 2 | $40 Copayment | $40 Copayment | Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. If the Member chooses to purchase a Brand-Name Prescription for which an approved Generic is available, the Member will pay the Value Drug Copayment, plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount. |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you need drugs to treat your illness or condition<br><br>More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-4tier-formulary2017 | Tier 3 | $70 Copayment | $70 Copayment | Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. If the Member chooses to purchase a Brand-Name Prescription for which an approved Generic is available, the Member will pay the Value Drug Copayment, plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount. |
| | Tier 4 | 10% Coinsurance up to $150 per prescription | 10% Coinsurance up to $150 per prescription | Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. If the Member chooses to purchase a Brand-Name Prescription for which an approved Generic is available, the Member will pay the Value Drug Copayment, plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount. |
| | Tier 5 | Not Applicable | Not Applicable | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| | Physician/Surgeon Fees | 30% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| If you need immediate medical attention | Emergency room services | 30% Coinsurance after deductible | 30% Coinsurance after deductible | None |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you need immediate medical attention | Emergency medical transportation | 30% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| | Urgent care | $55 Copayment | 50% Coinsurance after deductible | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% Coinsurance after deductible | 50% Coinsurance after deductible | Must obtain authorization. |
| | Physician/surgeon fees | 30% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| If you have mental health, behavioral health or substance abuse needs | Mental/Behavioral health outpatient services | $40 Copayment /office visit and 30% Coinsurance other outpatient services after deductible | 50% Coinsurance after deductible | May be required to obtain authorization |
| | Mental/Behavioral health inpatient services | 30% Coinsurance after deductible | 50% Coinsurance after deductible | Must obtain authorization |
| | Substance use disorder inpatient services | 30% Coinsurance after deductible | 50% Coinsurance after deductible | Must obtain authorization |
| | Substance use disorder outpatient services | $40 Copayment /office visit and 30% Coinsurance other outpatient services after deductible | 50% Coinsurance after deductible | May be required to obtain authorization |
| If you are pregnant | Prenatal and postnatal care | $55 Copayment /office visit | 50% Coinsurance after deductible | None |
| | Delivery and all inpatient services | 30% Coinsurance after deductible | 50% Coinsurance after deductible | May be required to obtain authorization |
| If you need help recovering or have other special health needs | Home health care | 30% Coinsurance after deductible | 50% Coinsurance after deductible | Must obtain authorization |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you need help recovering or have other special health needs | Rehabilitation services | 30% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| | Habilitation services | 30% Coinsurance after deductible | 50% Coinsurance after deductible | None |
| | Skilled nursing care | 30% Coinsurance after deductible | 50% Coinsurance after deductible | Must obtain authorization |
| | Durable medical equipment | 30% Coinsurance after deductible | 50% Coinsurance after deductible | Prior authorization may be required |
| | Hospice service | 30% Coinsurance after deductible | 50% Coinsurance after deductible | Must obtain authorization |
| If your child needs dental or eye care | Eye exam | Not covered | Not covered | None |
| | Glasses | Not covered | Not covered | None |
| | Dental check-up | Not covered | Not covered | None |

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- 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.)**

- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing

## 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 1-800-495-2583. 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.

## 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: Louisiana Department of Insurance 1-800-259-5300 or www.ldi.state.la.us

## 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.

## Language Access Services:

Para obtener asistencia en Español, llame al 1-800-495-2583.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

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 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**: $3,749
- **Patient pays**: $3,791

### 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 | $2,000 |
| Co-pays | $900 |
| Co-insurance | $741 |
| Limits Or Exclusions | $150 |
| **Total** | $3,791 |

## Managing Type 2 Diabetes
Routine maintenance of a well-controlled condition

- **Amount owed to providers**: $5,400
- **Plan pays**: $3,049
- **Patient pays**: $2,351

### Sample Care Costs:

| | |
|---|---:|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory Tests | $100 |
| Vaccines, other Preventive | $100 |
| **Total** | $5,400 |

### Patient Pays:

| | |
|---|---:|
| Deductibles | $1,272 |
| Co-pays | $1,000 |
| Co-insurance | $0 |
| Limits Or Exclusions | $79 |
| **Total** | $2,351 |

# 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 condition of preexisting condition.
- All services and treatments started and ended in the same 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 comparison 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**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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.



Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc., and Southern National Life Insurance Company, Inc., are subsidiaries of Blue Cross and Blue Shield of Louisiana. All three companies are independent licensees of the Blue Cross and Blue Shield Association.

# 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 disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

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

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

**الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.**
**إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).**

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز (TTY 711) 1-800-711-5519 پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره (TTY 711) 1-800-711-5519 تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

**มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข** 1-800-711-5519 (TTY 711)

**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** or by calling **1-800-495-2583**.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the **overall deductible**? | For in-network providers:<br>**$3,000** Individual<br>For out-of-network providers:<br>**$6,000** Individual | You must pay all the costs up to the **deductible** amount before this health insurance 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 section 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 Common Medical Event section chart for other costs for services this plan covers. |
| Is there an **out-of-pocket limit** on my expenses? | Yes. For in-network providers:<br>**$5,000** Individual<br>For out-of-network providers:<br>**$10,000** Individual | 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**? | Premiums, Balance Billed 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**. |
| Is there an overall annual limit on what the insurer pays? | No Maximum Individual/No Maximum Family | The Common Medical Event section chart describes any limits on what the insurer will pay for *specific* covered services, such as office visits. |
| Does this plan use a **network** of **providers**? | Yes. See **www.bcbsla.com or call 1-800-495-2583** for a list of participating providers. | 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 terms in-network, **preferred** or participating for **providers** in their **network**. See the Common Medical Event section chart for how this plan pays different kinds of **providers**. |
| Do I need a referral to see a **specialist**? | No. You don't need a referral to see a specialist. | 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 the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**. |

- **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 $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you visit a health care **provider's** office or clinic | Primary care visit to treat an injury or illness | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Specialist Visit | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Other practitioner office visit | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Preventive care/screening/immunization | No charge | 40% Coinsurance | Prostate Cancer Screening –One (1) digital rectal exam per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. One (1) prostate-specific antigen (PSA) test per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. A second visit shall be permitted for follow-up treatment within sixty (60) days after the first visit if related to a condition diagnosed or treated during the visit and recommended by a Physician. Colorectal Cancer Screening Fecal occult blood test: One (1) every five (5) years for ages 50-75; additional screenings will be subject |

| | | | | |
|---|---|---|---|---|
| | | | | to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Flexible sigmoidoscopy: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Colonoscopy: One (1) every ten (10) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Abdominal Aortic Aneurysm Screening: One per Benefit Period for Men ages 65-75; Mammography Examination - One (1) every twelve (12) months; Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; Routine Pap Smear - One (1) per Benefit Period; Autism Screening: Ages 1-2; Developmental Screening: Ages 0-3; Hearing Screening: One per Benefit Period for Children Ages 0-21; Lead Screening: One per Benefit Period for Ages 0-6; Tuberculosis Screening: One per Benefit Period for Ages 0-21; Vision Screening: One per Benefit Period for Ages 0-21; |
| If you have a test | Diagnostic Test (x-ray, blood test) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization. |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you need drugs to treat your illness or condition<br><br>More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-2tier-formulary2017 | Tier 1 | 20% Coinsurance after deductible | 20% Coinsurance after deductible | Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Generic Drug Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. |
| | Tier 2 | 40% Coinsurance after deductible | 40% Coinsurance after deductible | Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Generic Drug Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. |
| | Tier 3 | Not Applicable | Not Applicable | |
| | Tier 4 | Not Applicable | Not Applicable | |
| | Tier 5 | Not Applicable | Not Applicable | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Physician/Surgeon Fees | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| If you need immediate medical attention | Emergency room services | 20% Coinsurance after deductible | 20% Coinsurance after deductible | None |
| | Emergency medical transportation | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Urgent care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization. |
| | Physician/surgeon fees | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| If you have mental health, behavioral health or substance abuse needs | Mental/Behavioral health outpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | May be required to obtain authorization |
| | Mental/Behavioral health inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |
| | Substance use disorder inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |
| | Substance use disorder outpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | May be required to obtain authorization |
| If you are pregnant | Prenatal and postnatal care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Covered |
| | Delivery and all inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | May be required to obtain authorization |
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |
| | Rehabilitation services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Habilitation services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Skilled nursing care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |
| | Durable medical equipment | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Prior authorization may be required |
| | Hospice service | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If your child needs dental or eye care | Eye exam | Not covered | Not covered | None |
| | Glasses | Not covered | Not covered | None |
| | Dental check-up | Not covered | Not covered | None |

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- 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.)**

- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing

## 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 1-800-495-2583. 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.

## 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: Louisiana Department of Insurance 1-800-259-5300 or www.ldi.state.la.us

## 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.

## Language Access Services:

Para obtener asistencia en Español, llame al 1-800-495-2583.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

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 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**: $3,534
- **Patient pays**: $4,006

**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 | $3,000 |
| Co-pays | $0 |
| Co-insurance | $856 |
| Limits Or Exclusions | $150 |
| **Total** | $4,006 |

## Managing Type 2 Diabetes

Routine maintenance of a well-controlled condition

- **Amount owed to providers**: $5,400
- **Plan pays**: $1,867
- **Patient pays**: $3,533

**Sample Care Costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory Tests | $100 |
| Vaccines, other Preventive | $100 |
| **Total** | $5,400 |

**Patient Pays:**

| | |
|---|---|
| Deductibles | $3,000 |
| Co-pays | $0 |
| Co-insurance | $454 |
| Limits Or Exclusions | $79 |
| **Total** | $3,533 |

# 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 condition of preexisting condition.
- All services and treatments started and ended in the same 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 comparison 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**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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.



Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc., and Southern National Life Insurance Company, Inc., are subsidiaries of Blue Cross and Blue Shield of Louisiana. All three companies are independent licensees of the Blue Cross and Blue Shield Association.

# 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 disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d’identification. Si vous souffrez d’une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

**الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.**
**إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).**

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود
کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

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تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

**มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน**
**สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข** 1-800-711-5519 (TTY 711)

**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** or by calling **1-800-495-2583**.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the **overall deductible**? | For in-network providers:<br>**$3,000** Individual / **$6,000** Family<br>For out-of-network providers:<br>**$6,000** Individual / **$12,000** Family | You must pay all the costs up to the **deductible** amount before this health insurance 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 section 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 Common Medical Event section chart for other costs for services this plan covers. |
| Is there an **out-of-pocket limit** on my expenses? | Yes. For in-network providers:<br>**$5,000** Individual / **$10,000** Family<br>For out-of-network providers:<br>**$10,000** Individual / **$20,000** Family | 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**? | Premiums, Balance Billed 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**. |
| Is there an overall annual limit on what the insurer pays? | No Maximum Individual/No Maximum Family | The Common Medical Event section chart describes any limits on what the insurer will pay for *specific* covered services, such as office visits. |
| Does this plan use a **network** of **providers**? | Yes. See **www.bcbsla.com or call 1-800-495-2583** for a list of participating providers. | 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 terms in-network, **preferred** or participating for **providers** in their **network**. See the Common Medical Event section chart for how this plan pays different kinds of **providers**. |
| Do I need a referral to see a **specialist**? | No. You don't need a referral to see a specialist. | 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 the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**. |

- **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 $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you visit a health care **provider's** office or clinic | Primary care visit to treat an injury or illness | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Specialist Visit | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Other practitioner office visit | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Preventive care/screening/immunization | No charge | 40% Coinsurance | Prostate Cancer Screening –One (1) digital rectal exam per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. One (1) prostate-specific antigen (PSA) test per Benefit Period, for Members fifty (50) years of age or older, and as recommended by a Physician if the Member is over forty (40) years of age. A second visit shall be permitted for follow-up treatment within sixty (60) days after the first visit if related to a condition diagnosed or treated during the visit and recommended by a Physician. Colorectal Cancer Screening Fecal occult blood test: One (1) every five (5) years for ages 50-75; additional screenings will be subject |

| | | | | |
|---|---|---|---|---|
| | | | | to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Flexible sigmoidoscopy: One (1) every five (5) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Colonoscopy: One (1) every ten (10) years for ages 50-75; additional screenings will be subject to Deductible Amounts and Coinsurance percentages shown in the Schedule of Benefits. Abdominal Aortic Aneurysm Screening: One per Benefit Period for Men ages 65-75; Mammography Examination - One (1) every twelve (12) months; Osteoporosis Screening: One (1) per Benefit Period for Women age 60 and older; Routine Pap Smear - One (1) per Benefit Period; Autism Screening: Ages 1-2; Developmental Screening: Ages 0-3; Hearing Screening: One per Benefit Period for Children Ages 0-21; Lead Screening: One per Benefit Period for Ages 0-6; Tuberculosis Screening: One per Benefit Period for Ages 0-21; Vision Screening: One per Benefit Period for Ages 0-21; |
| If you have a test | Diagnostic Test (x-ray, blood test) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization. |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you need drugs to treat your illness or condition<br><br>More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-2tier-formulary2017 | Tier 1 | 20% Coinsurance after deductible | 20% Coinsurance after deductible | Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Generic Drug Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. |
| | Tier 2 | 40% Coinsurance after deductible | 40% Coinsurance after deductible | Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Generic Drug Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. |
| | Tier 3 | Not Applicable | Not Applicable | |
| | Tier 4 | Not Applicable | Not Applicable | |
| | Tier 5 | Not Applicable | Not Applicable | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Physician/Surgeon Fees | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| If you need immediate medical attention | Emergency room services | 20% Coinsurance after deductible | 20% Coinsurance after deductible | None |
| | Emergency medical transportation | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Urgent care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization. |
| | Physician/surgeon fees | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| If you have mental health, behavioral health or substance abuse needs | Mental/Behavioral health outpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | May be required to obtain authorization |
| | Mental/Behavioral health inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |
| | Substance use disorder inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |
| | Substance use disorder outpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | May be required to obtain authorization |
| If you are pregnant | Prenatal and postnatal care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Covered |
| | Delivery and all inpatient services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | May be required to obtain authorization |
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |
| | Rehabilitation services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Habilitation services | 20% Coinsurance after deductible | 40% Coinsurance after deductible | None |
| | Skilled nursing care | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |
| | Durable medical equipment | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Prior authorization may be required |
| | Hospice service | 20% Coinsurance after deductible | 40% Coinsurance after deductible | Must obtain authorization |

| | | Your cost if you use an | | |
|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **In-network Provider** | **Out-of-network Provider** | **Limitations & Exceptions** |
| If your child needs dental or eye care | Eye exam | Not covered | Not covered | None |
| | Glasses | Not covered | Not covered | None |
| | Dental check-up | Not covered | Not covered | None |

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- 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.)**

- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing

## 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 1-800-495-2583. 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.

## 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: Louisiana Department of Insurance 1-800-259-5300 or www.ldi.state.la.us

## 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.

## Language Access Services:

Para obtener asistencia en Español, llame al 1-800-495-2583.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

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 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**: $3,534
- **Patient pays**: $4,006

**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 | $3,000 |
| Co-pays | $0 |
| Co-insurance | $856 |
| Limits Or Exclusions | $150 |
| **Total** | $4,006 |

## Managing Type 2 Diabetes

Routine maintenance of a well-controlled condition

- **Amount owed to providers**: $5,400
- **Plan pays**: $1,867
- **Patient pays**: $3,533

**Sample Care Costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory Tests | $100 |
| Vaccines, other Preventive | $100 |
| **Total** | $5,400 |

**Patient Pays:**

| | |
|---|---|
| Deductibles | $3,000 |
| Co-pays | $0 |
| Co-insurance | $454 |
| Limits Or Exclusions | $79 |
| **Total** | $3,533 |

# 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 condition of preexisting condition.
- All services and treatments started and ended in the same 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 comparison 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**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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.

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# 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 disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

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

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

**الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.**
**إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).**

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ,
ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫລັງຂອງບັດປະຈໍາຕົວຂອງທ່ານ.
ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود
کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است
تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره (TTY 711) 1-800-711-5519 تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

**มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน**
**สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข** 1-800-711-5519 (TTY 711)

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