



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bcbsla.com](http://www.bcbsla.com) or call 1-800-495-2583. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary.

You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-495-2583 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | For <u>network providers</u> \$1,000 individual or \$3,000 family; for <u>out-of-network providers</u> \$2,000 individual or \$6,000 family  | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | 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> .                                            |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | Yes. \$500 for <u>prescription drug coverage</u> and \$50 for pediatric dental. There are no other specific <u>deductibles</u> .             | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For <u>network providers</u> \$7,900 individual / \$15,800 family; for <u>out-of-network providers</u> \$15,800 individual / \$31,600 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.bcbsla.com">www.bcbsla.com</a> or call 1-800-495-2583 for a list of <u>network providers</u> .                  | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No.                                                                                                                                          | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                   | Services You May Need                            | What You Will Pay                                   |                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        |                                                  | Network Provider (You will pay the least)           | Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$40 <u>Copayment</u>                               | 40% <u>Coinsurance</u>                          | If you have a <u>copayment plan</u> , the PCP <u>copayment</u> may be reduced or waived when services are rendered by a Quality Blue Primary Care <u>Provider</u> (QBPC).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                        | Specialist Visit                                 | \$60 <u>Copayment</u>                               | 40% <u>Coinsurance</u>                          | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                        | <u>Preventive care/screening/immunization</u>    | No charge. <b><u>Deductible</u></b> does not apply. | 40% <u>Coinsurance</u>                          | Prostate Cancer <u>Screening</u> , Colorectal Cancer <u>Screening</u> , Flexible Sigmoidoscopy, Colonoscopy, Abdominal Aortic Aneurysm <u>Screening</u> , Mammography, Osteoporosis <u>Screening</u> , Routine Pap Smear, Autism <u>Screening</u> , Developmental <u>Screening</u> , Hearing <u>Screening</u> , Lead <u>Screening</u> , Tuberculosis <u>Screening</u> , Vision <u>Screening</u> . For more information about <u>Preventive Care &amp; Wellness</u> limitations and exceptions, see the brochure at <a href="https://www.bcbsla.com/preventive">https://www.bcbsla.com/preventive</a> .<br><br>You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test                                     | <u>Diagnostic Test</u> (x-ray, blood work)       | 20% <u>Coinsurance</u>                              | 40% <u>Coinsurance</u>                          | May be required to obtain authorization.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                        | Imaging (CT/PET scans, MRIs)                     | 20% <u>Coinsurance</u>                              | 40% <u>Coinsurance</u>                          | Must obtain authorization                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| Common Medical Event                                                                                                                                                                                                                                           | Services You May Need                          | What You Will Pay                                   |                                                     | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                |                                                | Network Provider (You will pay the least)           | Out-of-Network Provider (You will pay the most)     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b><br><b>More information about prescription drug coverage is available at</b><br><a href="http://www.bcbsla.com/pharmacy-3tier-formulary2019">http://www.bcbsla.com/pharmacy-3tier-formulary2019</a> | Tier 1                                         | \$7 <u>Copayment</u>                                | \$7 <u>Copayment</u>                                | 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 Tier 1 Drug <u>Copayment</u> , plus the cost difference between the Brand-Name Drug and the Generic version. The Brand-Name Drug <u>Copayment</u> is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount. |
|                                                                                                                                                                                                                                                                | Tier 2                                         | 20% <u>Coinsurance</u> up to \$250 per prescription | 20% <u>Coinsurance</u> up to \$250 per prescription | See Drug Tier 1 Limitations, Exceptions, & Other Important Information.                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                | Tier 3                                         | 30% <u>Coinsurance</u> up to \$250 per prescription | 30% <u>Coinsurance</u> up to \$250 per prescription | See Drug Tier 1 Limitations, Exceptions, & Other Important Information.                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                | Tier 4                                         | Not Applicable                                      | Not Applicable                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                | Tier 5                                         | Not Applicable                                      | Not Applicable                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                          | Facility fee (e.g., ambulatory surgery center) | 20% <u>Coinsurance</u>                              | 40% <u>Coinsurance</u>                              | Authorization needed. Failure to do so may result in a 30% penalty.                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                | Physician/Surgeon Fees                         | 20% <u>Coinsurance</u>                              | 40% <u>Coinsurance</u>                              | Authorization needed. Failure to do so may result in a 30% penalty.                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                 | <u>Emergency room care</u>                     | \$350 <u>Copayment</u>                              | \$350 <u>Copayment</u>                              | Emergency Room <u>Copayment</u> is waived if admitted as in-patient.                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                | <u>Emergency medical transportation</u>        | \$50 <u>Copayment</u>                               | 40% <u>Coinsurance</u>                              | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                | <u>Urgent care</u>                             | \$60 <u>Copayment</u>                               | 40% <u>Coinsurance</u>                              | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                                             | Facility fee (e.g., hospital room)             | 20% <u>Coinsurance</u>                              | 40% <u>Coinsurance</u>                              | Must obtain authorization                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                | Physician/surgeon fees                         | 20% <u>Coinsurance</u>                              | 40% <u>Coinsurance</u>                              | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Common Medical Event                                                            | Services You May Need                        | What You Will Pay                                                                        |                                                 | Limitations, Exceptions, & Other Important Information |
|---------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------|
|                                                                                 |                                              | Network Provider (You will pay the least)                                                | Out-of-Network Provider (You will pay the most) |                                                        |
| <b>If you need mental health, behavioral health or substance abuse services</b> | Mental/Behavioral health outpatient services | \$40 <u>Copayment</u> /office visit and 20% <u>Coinsurance</u> other outpatient services | 40% <u>Coinsurance</u>                          | May be required to obtain authorization                |
|                                                                                 | Mental/Behavioral health inpatient services  | 20% <u>Coinsurance</u>                                                                   | 40% <u>Coinsurance</u>                          | Must obtain authorization                              |
|                                                                                 | Substance use disorder inpatient services    | 20% <u>Coinsurance</u>                                                                   | 40% <u>Coinsurance</u>                          | Must obtain authorization                              |
|                                                                                 | Substance use disorder outpatient services   | \$40 <u>Copayment</u> /office visit and 20% <u>Coinsurance</u> other outpatient services | 40% <u>Coinsurance</u>                          | May be required to obtain authorization                |
| <b>If you are pregnant</b>                                                      | Office visits                                | No charge                                                                                | 40% <u>Coinsurance</u>                          | None                                                   |
|                                                                                 | Childbirth/delivery professional services    | \$60 <u>Copayment</u> / pregnancy                                                        | 40% <u>Coinsurance</u>                          | May be required to obtain authorization                |
|                                                                                 | Childbirth/delivery facility services        | 20% <u>Coinsurance</u>                                                                   | 40% <u>Coinsurance</u>                          | May be required to obtain authorization                |
| <b>If you need help recovering or have other special health needs</b>           | <u>Home health care</u>                      | 20% <u>Coinsurance</u>                                                                   | 40% <u>Coinsurance</u>                          | Must obtain authorization                              |
|                                                                                 | <u>Rehabilitation services</u>               | \$40 <u>Copayment</u>                                                                    | 40% <u>Coinsurance</u>                          | None                                                   |
|                                                                                 | <u>Habilitation services</u>                 | \$40 <u>Copayment</u>                                                                    | 40% <u>Coinsurance</u>                          | None                                                   |
|                                                                                 | <u>Skilled nursing care</u>                  | 20% <u>Coinsurance</u>                                                                   | 40% <u>Coinsurance</u>                          | Must obtain authorization                              |
|                                                                                 | <u>Durable medical equipment</u>             | 20% <u>Coinsurance</u>                                                                   | 40% <u>Coinsurance</u>                          | Prior authorization may be required                    |
|                                                                                 | <u>Hospice services</u>                      | 20% <u>Coinsurance</u>                                                                   | 40% <u>Coinsurance</u>                          | Must obtain authorization                              |

| Common Medical Event                   | Services You May Need      | What You Will Pay                         |                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                |
|----------------------------------------|----------------------------|-------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                            | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                       |
| If your child needs dental or eye care | Children's eye exam        | No charge                                 | 100% <u>Coinurance</u>                          | These services are for members under the age of nineteen (19). Members who attain age 19 during a Policy Year will continue to have these Benefits until the end of that Policy Year. |
|                                        | Children's glasses         | No charge                                 | 100% <u>Coinurance</u>                          | These services are for members under the age of nineteen (19). Members who attain age 19 during a Policy Year will continue to have these Benefits until the end of that Policy Year. |
|                                        | Children's dental check-up | No charge                                 | No charge                                       | These services are for members under the age of nineteen (19). Members who attain age 19 during a Policy Year will continue to have these Benefits until the end of that Policy Year. |

## 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)

- |                       |                                                                         |                            |
|-----------------------|-------------------------------------------------------------------------|----------------------------|
| • Acupuncture         | • Expected abortions (except when the life of the mother is endangered) | • Routine eye care (Adult) |
| • Bariatric surgery   | • Hearing aids (Adult)                                                  | • Routine foot care        |
| • Cosmetic surgery    | • Infertility treatment                                                 | • Weight Loss Programs     |
| • Dental care (Adult) | • Long-term care                                                        |                            |

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

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

**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: 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 Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300 .

### Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet 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, llama a al 1-800-495-2583.

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

Chinese(中文): 如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-495-2583.

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

## 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 **\$1,000**
- Specialist copayment **\$60**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Service  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

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

| Cost Sharing |         |
|--------------|---------|
| Deductibles* | \$1,040 |
| Copayments   | \$60    |
| Coinsurance  | \$1,590 |

#### What isn't covered

|                      |      |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$2,750</b> |
|-----------------------------------|----------------|

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$1,000**
- Specialist copayment **\$60**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

#### 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>\$7,400</b> |
|---------------------------|----------------|

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

| Cost Sharing |       |
|--------------|-------|
| Deductibles  | \$560 |
| Copayments   | \$610 |
| Coinsurance  | \$990 |

#### What isn't covered

|                      |      |
|----------------------|------|
| Limits or exclusions | \$90 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$2,250</b> |
|-----------------------------------|----------------|

### Mia's Simple Fracture

(in-network emergency room and follow up care)

- The plan's overall deductible **\$1,000**
- Specialist copayment **\$60**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

#### 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>\$1,900</b> |
|---------------------------|----------------|

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

| Cost Sharing |       |
|--------------|-------|
| Deductibles  | \$200 |
| Copayments   | \$560 |
| Coinsurance  | \$0   |

#### What isn't covered

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |              |
|-----------------------------------|--------------|
| <b>The total Mia would pay is</b> | <b>\$760</b> |
|-----------------------------------|--------------|

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.





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](http://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>.

# 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. ຖ້າທ່ານຫຼຸບ ບໍ່ໄດ້, 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 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)