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: **$1,000** Individual / **$3,000** Family For out-of-network providers: **$2,000** Individual / **$6,000** 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?	Yes. **$500** for Prescription Drugs. **$50** for Pediatric Dental.	You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an **out-of-pocket limit** on my expenses?	Yes. For in-network providers: **$5,000** Individual / **$10,000** Family For out-of-network providers: **$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	$40 Copayment	40% 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	$60 Copayment	40% Coinsurance after deductible	None
	Other practitioner office visit	$40 Copayment	40% Coinsurance after deductible	None
	Preventive care/screening/immunization	No charge	40% Coinsurance after deductible	None
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 More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-4tier-formulary2016	Tier 1	$7 Copayment after pharmacy deductible	$7 Copayment after pharmacy deductible	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	$30 Copayment after pharmacy deductible	$30 Copayment after pharmacy deductible	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 More information about **prescription drug coverage** is available at http://www.bcbsla.com/pharmacy-4tier-formulary2016	Tier 3	$70 Copayment after pharmacy deductible	$70 Copayment after pharmacy deductible	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 after pharmacy deductible up to $150 per prescription	10% Coinsurance after pharmacy deductible 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)	20% Coinsurance after deductible	40% Coinsurance after deductible	Authorization needed. Failure to do so may result in a 30% penalty.
	Physician/Surgeon Fees	20% Coinsurance after deductible	40% Coinsurance after deductible	Authorization needed. Failure to do so may result in a 30% penalty.
If you need immediate medical attention	Emergency room services	$150 Copayment	$150 Copayment	Emergency Room Copayment is waived if admitted as in-patient.

		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	$50 Copayment	40% Coinsurance after deductible	None
	Urgent care	$60 Copayment	40% Coinsurance after deductible	None
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	$40 Copayment /office visit and No charge other outpatient services 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	$40 Copayment /office visit and No charge other outpatient services after deductible	40% Coinsurance after deductible	May be required to obtain authorization
If you are pregnant	Prenatal and postnatal care	$60 Copayment / pregnancy	40% Coinsurance after deductible	None
	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

		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	20% Coinsurance after deductible	40% Coinsurance after deductible	None
	Habilitation services	$40 Copayment	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	None
	Hospice service	20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization
If your child needs dental or eye care	Eye exam	No charge	100% Coinsurance	Services are provided for children up to age 19.
	Glasses	No charge	100% Coinsurance	Services are provided for children up to age 19.
	Dental check-up	No charge	100% Coinsurance	Services are provided for children up to the age 19. Non-Participating Providers do not limit their charges and may bill you for the difference between their charge and the benefit paid by the policy.

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 (Adult)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other 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:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-495-2583. You may also contact your state insurance department at Louisiana Department of Insurance at 1-800-259-5300 or www.ldi.state.la.us.

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.

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**: $5,613
- **Patient pays**: $1,927

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	$1,023
Co-pays	$60
Co-insurance	$694
Limits Or Exclusions	$150
Total	$1,927

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

- **Amount owed to providers**: $5,400
- **Plan pays**: $3,122
- **Patient pays**: $2,278

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	$1,500
Co-pays	$645
Co-insurance	$54
Limits Or Exclusions	$79
Total	$2,278

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.