




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 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 or call 1-800-363-9150 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Terrebonne General Health Providers: \$500 individual/family; <u>network providers</u> \$750 individual/family; for <u>out-of-network providers</u> \$1,000 individual/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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive Care</u> and Wellness 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$150 individual or \$450 family for <u>prescription drug coverage</u> . There are no other specific deductibles.	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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Terrebonne General Health Providers: \$2,500 individual or \$7,500 family; <u>network providers</u> \$3,000 individual or \$9,000 family; for <u>out-of-network providers</u> Unlimited	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>Balance Billing</u> Charges, and Health Care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a network provider ?	Yes. See www.bcbsla.com or call 1-800-495-2583 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 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
		Employer Preferred Option Provider (You will pay the least)	Network Provider	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	10% Coinsurance after deductible	30% Coinsurance after deductible	70% Coinsurance after deductible	None
	Specialist visit	10% Coinsurance after deductible	30% Coinsurance after deductible	70% Coinsurance after deductible	None
	Other practitioner office visit	10% Coinsurance after deductible	30% Coinsurance after deductible	70% Coinsurance after deductible	None
	Preventive care/screening/immunization	No Cost	No Cost	70% Coinsurance after deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance ; deductible waived	30% Coinsurance after deductible	70% Coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	0% Coinsurance ; deductible waived	30% Coinsurance after deductible	70% Coinsurance after deductible	Must obtain authorization.

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bcbsla.com or www.healthcare.gov or call 1-800-363-9150 to request a copy.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Employer Preferred Option Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.medimpact.com	Generic Drugs	Retail: \$10 <u>Copayment</u> , Mail Order: \$25 <u>Copayment</u> or 20% of the cost of the drug, whichever is greater.	Retail: \$10 <u>Copayment</u> , Mail Order: \$25 <u>Copayment</u> or 20% of the cost of the drug, whichever is greater.	Retail: \$10 <u>Copayment</u> , Mail Order: \$25 <u>Copayment</u> or 20% of the cost of the drug, whichever is greater.	Deductible does not apply to Generic drugs or Contraceptives as required by federal law. Benefit covers a 30 day supply or a 90 day supply of a maintenance legend drug, whichever is greater. Mandatory 90 Day Supply for maintenance medications. Amounts paid by Manufacturer Assistance Program Amounts do not count towards deductibles or Out of Pocket for Specialty Drugs.
	Preferred Brand Drugs	Retail: \$25 <u>Copayment</u> , Mail Order: \$62.50 <u>Copayment</u> or 30% of the cost of the drug, whichever is greater.	Retail: \$25 <u>Copayment</u> , Mail Order: \$62.50 <u>Copayment</u> or 30% of the cost of the drug, whichever is greater.	Retail: \$25 <u>Copayment</u> , Mail Order: \$62.50 <u>Copayment</u> or 30% of the cost of the drug, whichever is greater.	
	Non-Preferred Brand Drugs	Retail: \$50 <u>Copayment</u> , Mail Order: \$125 <u>Copayment</u> or 50% of the cost of the drug, whichever is greater.	Retail: \$50 <u>Copayment</u> , Mail Order: \$125 <u>Copayment</u> or 50% of the cost of the drug, whichever is greater.	Retail: \$50 <u>Copayment</u> , Mail Order: \$125 <u>Copayment</u> or 50% of the cost of the drug, whichever is greater.	
	Specialty Drugs	Generic: Retail: \$10 <u>Copayment</u> , Mail Order: \$25 <u>Copayment</u> or 20% of the cost of the drug, whichever is greater.	Generic: Retail: \$10 <u>Copayment</u> , Mail Order: \$25 <u>Copayment</u> or 20% of the cost of the drug, whichever is greater.	Generic: Retail: \$10 <u>Copayment</u> , Mail Order: \$25 <u>Copayment</u> or 20% of the cost of the drug, whichever is greater.	Deductible does not apply to Generic drugs or Contraceptives as required by federal law. Specialty drugs are limited to a 30 day supply. Amounts paid by Manufacturer Assistance Program Amounts do not count towards deductibles or Out of Pocket for Specialty Drugs.

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bcbsla.com or www.healthcare.gov or call 1-800-363-9150 to request a copy.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Employer Preferred Option Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
		Preferred & Non-Preferred: Retail: \$25 <u>Copayment</u> , Mail Order: \$62.50 <u>Copayment</u> or 30% of the cost of the drug, whichever is greater.	Preferred & Non-Preferred: Retail: \$25 <u>Copayment</u> , Mail Order: \$62.50 <u>Copayment</u> or 30% of the cost of the drug, whichever is greater.	Preferred & Non-Preferred: Retail: \$25 <u>Copayment</u> , Mail Order: \$62.50 <u>Copayment</u> or 30% of the cost of the drug, whichever is greater.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>Coinsurance</u> after <u>deductible</u>	\$1,000 <u>Copayment</u> / \$1,500 <u>Copayment</u> then 30% <u>Coinsurance</u> after <u>deductible</u>	\$1,500 <u>Copayment</u> then 70% <u>Coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>Copayment</u>	30% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	Copayment waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	Ground: 10% <u>Coinsurance</u> after <u>deductible</u> Air: 10% <u>Coinsurance</u> after <u>deductible</u>	Ground: 30% <u>Coinsurance</u> after <u>deductible</u> Air: 30% <u>Coinsurance</u> after <u>deductible</u>	Ground: 70% <u>Coinsurance</u> after <u>deductible</u> Air: 30% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>Coinsurance</u> after <u>deductible</u>	\$1,000 <u>Copayment</u> / \$1,500 <u>Copayment</u> then 30% <u>Coinsurance</u> after <u>deductible</u>	\$1,500 <u>Copayment</u> then 70% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bcbsla.com or www.healthcare.gov or call 1-800-363-9150 to request a copy.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Employer Preferred Option Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral outpatient services	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	None
	Mental/Behavioral inpatient services	10% <u>Coinsurance</u> after <u>deductible</u>	\$1,000 <u>Copayment</u> / \$1,500 <u>Copayment</u> then 30% <u>Coinsurance</u> after <u>deductible</u>	\$1,500 <u>Copayment</u> then 70% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
	Substance use disorder outpatient services	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	None
	Substance use disorder inpatient services	10% <u>Coinsurance</u> after <u>deductible</u>	\$1,000 <u>Copayment</u> / \$1,500 <u>Copayment</u> then 30% <u>Coinsurance</u> after <u>deductible</u>	\$1,500 <u>Copayment</u> then 70% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
If you are pregnant	Office visits	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	Dependent maternity is covered under this Benefit Plan.
	Childbirth/delivery professional services	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	Authorization required if the mother's length of stay exceeds 48 hours following a vaginal delivery or 96 hours following a caesarean section.
	Childbirth/delivery facility services	10% <u>Coinsurance</u> after <u>deductible</u>	\$1,000 <u>Copayment</u> / \$1,500 <u>Copayment</u> then 30% <u>Coinsurance</u> after <u>deductible</u>	\$1,500 <u>Copayment</u> then 70% <u>Coinsurance</u> after <u>deductible</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization. Limited to 40 visits per Benefit Period.
	<u>Rehabilitation services</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	Physical & Occupational Therapy have a combined 30 visit limit.
	<u>Habilitation services</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	Physical & Occupational Therapy have a combined 30 visit limit.

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bcbsla.com or www.healthcare.gov or call 1-800-363-9150 to request a copy.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Employer Preferred Option Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	10% <u>Coinsurance</u> after <u>deductible</u>	\$1,000 <u>Copayment</u> / \$1,500 <u>Copayment</u> then 30% <u>Coinsurance</u> after <u>deductible</u>	\$1,500 <u>Copayment</u> then 70% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization. Limited to 90 visits per Benefit Period.
	<u>Durable medical equipment</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Hospice services</u>	10% <u>Coinsurance</u> after <u>deductible</u>	30% <u>Coinsurance</u> after <u>deductible</u>	70% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered

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.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Cosmetic Surgery | <ul style="list-style-type: none"> • Dental Care • Hearing Aids • Infertility Treatment • Long-Term Care | <ul style="list-style-type: none"> • Routine Eye Care • Routine Foot Care • Weight Loss Programs |
|--|--|---|

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

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Chiropractic Care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the United States | <ul style="list-style-type: none"> • Private-Duty Nursing |
|---|---|--|

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bcbsla.com or www.healthcare.gov or call 1-800-363-9150 to request a copy.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.Healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-495-2583

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

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

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

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

Questions: Call 1-800-363-9150

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bcbsla.com or www.healthcare.gov or call 1-800-363-9150 to request a copy.

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 \$750
- Specialist coinsurance 30%
- Hospital (facility) copayment \$1,000
- Other coinsurance 30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$820
Coinsurance	\$1,430
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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

- The plan's overall deductible \$750
- Specialist coinsurance 30%
- Hospital (facility) copayment \$1,000
- Other coinsurance 30%

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*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$820
Coinsurance	\$120
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,900

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

- The plan's overall deductible \$750
- Specialist insurance 30%
- Hospital (facility) copayment \$1,000
- Other coinsurance 30%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$760
Copayments	\$0
Coinsurance	\$610
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,370