




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 1-800-495-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; For network providers \$4,300 individual / \$12,900 family; for out-of-network providers \$12,900 individual or \$38,700 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care and Wellness are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	\$0 at IHCP or with IHCP referral at non-IHCP; or Yes, \$500 for prescription drug coverage or Yes, \$50 for pediatric dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers \$9,450 individual / \$18,900 family; for out-of-network providers \$28,350 individual / \$56,700 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Balance Billing 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.

<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.bcbsla.com or call 1-800-495-2583 for a list of <u>network providers</u>.</p>	<p>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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>

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

†Deductible does not apply.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	No charge	\$45 <u>Copayment</u> †	60% <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 or Affinity Health Group <u>Provider</u> .
	<u>Specialist</u> Visit	No charge	\$65 <u>Copayment</u> †	60% <u>Coinsurance</u>	If you have a <u>copayment plan</u> , the Specialist <u>copayment</u> may be reduced or waived when services are rendered by an Affinity Health Group <u>Provider</u> .
	<u>Preventive care/screening/immunization</u>	No charge	No charge. †	60% <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 & Wellness</u> limitations and exceptions, see the brochure at https://www.bcbsla.com/preventive . 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)	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	May be required to obtain authorization.
	Imaging (CT/PET scans, MRIs)	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.bcbsla.com/pharmacy-3tier-formulary2024	Tier 1 - Typically Generic Drugs	No charge	\$15 <u>Copayment</u>	\$15 <u>Copayment</u>	This <u>plan</u> has a 3-tier pharmacy benefit. This chart shows what you will typically pay for Generic, Preferred Brand, Non-Preferred Brand, and Specialty Drugs. What you will ultimately pay for drugs will depend on the Tier assigned to that drug. More information about <u>prescription drug coverage</u> is available at http://www.bcbsla.com/pharmacy-3tier-formulary2024 .
	Tier 2 - Typically Preferred Brand Drugs	No charge	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 - Typically Non-Preferred Brand Drugs	No charge	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 - Typically Specialty Drugs	No charge	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization. Failure to do so may result in a 30% penalty.
	Physician/Surgeon Fees	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization. Failure to do so may result in a 30% penalty.
If you need immediate medical attention	<u>Emergency room care</u>	No charge	40% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Balance billing</u> prohibited.
	<u>Emergency medical transportation</u>	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	What you will pay for OON emergency ambulance services may be less in some cases. <u>Balance billing</u> may be prohibited.
	<u>Urgent care</u>	No charge	\$65 <u>Copayment</u> †	60% <u>Coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization
	Physician/surgeon fees	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	None
If you need mental health, behavioral health or substance abuse services	Mental/Behavioral health outpatient services	No charge	\$45 <u>Copayment</u> † /office visit and 40% <u>Coinsurance</u> other outpatient services	60% <u>Coinsurance</u>	May be required to obtain authorization
	Mental/Behavioral health inpatient services	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization
	Substance use disorder inpatient services	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization
	Substance use disorder outpatient services	No charge	\$45 <u>Copayment</u> † /office visit and 40% <u>Coinsurance</u> other outpatient services	60% <u>Coinsurance</u>	May be required to obtain authorization
If you are pregnant	Office visits	No charge	\$65 <u>Copayment</u> † / pregnancy	60% <u>Coinsurance</u>	None
	Childbirth/delivery professional services	No charge	No charge	60% <u>Coinsurance</u>	May be required to obtain authorization
	Childbirth/delivery facility services	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	May be required to obtain authorization

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization
	<u>Rehabilitation services</u>	No charge	\$45 <u>Copayment</u> †	60% <u>Coinsurance</u>	None
	<u>Habilitation services</u>	No charge	\$45 <u>Copayment</u> †	60% <u>Coinsurance</u>	None
	<u>Skilled nursing care</u>	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization
	<u>Durable medical equipment</u>	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	May be required to obtain authorization
	<u>Hospice services</u>	No charge	40% <u>Coinsurance</u>	60% <u>Coinsurance</u>	Must obtain authorization
If your child needs dental or eye care	Children's eye exam	No charge	No charge	100% <u>Coinsurance</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	No charge	100% <u>Coinsurance</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	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.

Additional information about Limitations and Exceptions: If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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• Dental care (Adult) | <ul style="list-style-type: none">• Expected abortions (except when the life of the mother is endangered)• Infertility treatment• Long-term care | <ul style="list-style-type: none">• Routine eye care (Adult)• 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• Hearing aids | <ul style="list-style-type: none">• Non-emergency care when traveling outside the United States | <ul style="list-style-type: none">• Private-Duty Nursing |
|--|---|--|

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 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**

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 Minimum Value Standards? **Not Applicable**

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 -----

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** \$4,300
- **Specialist copayment** \$65
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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*)

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

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

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

- **The plan's overall deductible** \$4,300
- **Specialist copayment** \$65
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$60

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

- **The plan's overall deductible** \$4,300
- **Specialist copayment** \$65
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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.

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>.

