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?	For network providers $1,000 individual or $3,000 family; for out-of-network providers $3,000 individual or $9,000 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?	Yes. $500 for prescription drug coverage and $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 $9,100 individual / $18,200 family; for out-of-network providers $27,300 individual / $54,600 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**.
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.

†**Deductible** does not apply.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copayment †	40% Coinsurance	If you have a copayment plan, the PCP copayment may be reduced or waived when services are rendered by a Quality Blue Provider.
	Specialist Visit	$60 Copayment †	40% Coinsurance	None
	Preventive care/screening/immunization	No charge. †	40% Coinsurance	Prostate Cancer Screening, Colorectal Cancer Screening, Flexible Sigmoidoscopy, Colonoscopy, Abdominal Aortic Aneurysm Screening, Mammography, Osteoporosis Screening, Routine Pap Smear, Autism Screening, Developmental Screening, Hearing Screening, Lead Screening, Tuberculosis Screening, Vision Screening. For more information about Preventive Care & Wellness limitations and exceptions, see the brochure at https://www.bcbsla.com/preventive. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic Test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	May be required to obtain authorization.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	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 you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.bcbsla.com/pharmacy-3tier-formulary2023	Tier 1	$7 Copayment	$7 Copayment	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Tier 1 Drug Copayment amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.
	Tier 2	20% Coinsurance up to $250 per prescription	20% Coinsurance up to $250 per prescription	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3	30% Coinsurance up to $250 per prescription	30% Coinsurance 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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Must obtain authorization. Failure to do so may result in a 30% penalty.
	Physician/Surgeon Fees	20% Coinsurance	40% Coinsurance	Must obtain authorization. Failure to do so may result in a 30% penalty.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Balance billing prohibited.
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	Emergency air ambulance will be subject to the network provider cost share. Balance billing prohibited for emergency air ambulance.
	Urgent care	$60 Copayment †	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	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)	
If you need mental health, behavioral health or substance abuse services	Mental/Behavioral health outpatient services	$40 Copayment † /office visit and 20% Coinsurance other outpatient services	40% Coinsurance	May be required to obtain authorization
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder outpatient services	$40 Copayment † /office visit and 20% Coinsurance other outpatient services	40% Coinsurance	May be required to obtain authorization
If you are pregnant	Office visits	$60 Copayment † / pregnancy	40% Coinsurance	None
	Childbirth/delivery professional services	No charge	40% Coinsurance	May be required to obtain authorization
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Rehabilitation services	$40 Copayment †	40% Coinsurance	None
	Habilitation services	$40 Copayment †	40% Coinsurance	None
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Durable medical equipment	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
	Hospice services	20% Coinsurance	40% Coinsurance	Must obtain authorization

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If your child needs dental or eye care	Children's eye exam	No charge	100% Coinsurance	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% Coinsurance	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Expected abortions (except when the life of the mother is endangered)
- Infertility treatment
- Long-term care
- 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)

- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the United States
- 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, kwiijigo 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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,010
Copayments	$60
Coinsurance	$1,210
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,340**

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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$510
Copayments	$510
Coinsurance	$720
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,800**

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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,010
Copayments	$240
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,440**

*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**.

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).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ ຫ ່ ານຟຣີ. ຖ ້ າທ ່ ານຕ ້ ອງການບໍລິການນ ັ ້ ນ, ກະລ ຸ ນາໂທຫາພະແນກບໍລິການລ ູ ກຄ ้ າຕາມເບ ີ ໂທທ ີ ່ ຢ ู ່ ທາງຫ ັ ງຂອງບ ັ ດປະຈ ຳ ຕ ົ ວຂອງທ ່ ານ. ຖ ้ າທ ่ ານຫ ูบ ่ ่ ด ี, ຂ ่ ໃຫ ้ ໂທເບ ี 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)