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/ogb or call 1-800-392-4089. 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 1-800-392-4089 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers Individual: $400; Individual + 1: $800 or $1,200 individual + 2 or more; for out-of-network providers No Coverage	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 policy, the overall family **deductible** must be met before the **plan** begins to pay.
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?	No.	You don't have to meet **deductibles** for specific services, but see the Common Medical Events chart for other costs for services this **plan** covers.
What is the out-of-pocket limit for this plan?	For network providers Individual: $1,500; individual+ 1 (Medicare paying primary for 1): $4,000; individual + 1 (Medicare paying primary for 2): $2,000; individual + 2 or more (Medicare paying primary for 1) $6,500; individual + 2 or more (Medicare paying primary for 2) $4,000; or $2,500 individual + 2 or more (Medicare paying primary for 3); for out-of-network providers No Coverage	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**, the overall family **out-of-pocket limit** must be met.
What is not included in	Premiums, Balance Billing	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

the out-of-pocket limit?	Charges, and Health Care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See www.bcbsla.com/ogb or call **1-800-392-4089** 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
		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	$25 Copayment per visit	No Coverage	None
	Specialist visit	$50 Copayment per visit	No Coverage	None
	Other practitioner office visit	$25 Copayment per visit	No Coverage	None
	Preventive care/screening/ immunization	No Cost	No Coverage	Age and/or time restrictions apply.
If you have a test	Diagnostic test (x-ray, blood work)	Office, Free Standing Independent Diagnostic Testing Facility, or Contracted Reference Lab: 0% Coinsurance Outpatient Hospital: 0% Coinsurance after deductible	No Coverage	None
	Imaging (CT/PET scans, MRIs)	$50 Copayment per visit	No Coverage	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsla.com/ogb or by calling **EGWP – 888-996-0104 or Commercial – 877-300-1906**.	Generic Drugs (50% up to $30 Maximum per 31 day prescription, up to the $1,500 Out-of-Pocket Threshold per Person per Benefit Period)	$0 after Out-of-Pocket Threshold is met		Prescription Out-of-Pocket Maximum: $2,000.00 per Participant. Appetite suppressant drugs; Dietary supplements; Topical forms of Minoxidil; Nutritional or parenteral therapy; Vitamins and minerals, except as required by law; Drugs available over the counter; medical foods; bulk chemicals; any federal legend drug with an over the counter equivalent available. Utilization management criteria may apply to specific drugs or drug categories to be determined by Pharmacy Benefit Manager.
	Preferred Drugs (50% up to $55 Maximum per 31 day prescription, up to the $1,500 Out-of-Pocket Threshold per Person per Benefit Period)	$20 after Out-of-Pocket Threshold is met		
	Non-Preferred Drugs (65% up to $80 Maximum per 31 day prescription, up to the $1,500 Out-of-Pocket Threshold per Person per Benefit Period)	$40 after Out-of-Pocket Threshold is met		
	Specialty Drugs (50% up to $80 Maximum per 31 day prescription up to the $1,500 Out-of-Pocket Threshold per Person per Benefit Period)	$40 after Out-of-Pocket Threshold is met		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copayment per visit	No Coverage	None
	Physician/surgeon fees	0% Coinsurance after deductible	No Coverage	None
If you need immediate medical attention	Emergency room care	Facility - $200 Copayment Non-Facility Charges – 0% Coinsurance after deductible	Facility - $200 Copayment Non-Facility Charges – 0% Coinsurance after deductible	Facility copayment waived if admitted to the same facility.
	Emergency medical transportation	Ground-$50 Copayment per trip; Air-$250	Ground-$50 Copayment per trip; Air-$250 Copayment	What you will pay for OON emergency ambulance services may be less in some

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)	
		Copayment per trip	per trip	cases. Balance billing may be prohibited.
	Urgent care	$50 Copayment per visit	No Coverage	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment per day; maximum of $300 per admission	No Coverage	None
	Physician/surgeon fees	0% Coinsurance after deductible	No Coverage	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral outpatient services	$25 Copayment per visit	No Coverage	None
	Mental/Behavioral inpatient services	$100 Copayment per day; maximum of $300 per admission	No Coverage	None
	Substance use disorder outpatient services	$25 Copayment per visit	No Coverage	None
	Substance use disorder inpatient services	$100 Copayment per day; maximum of $300 per admission	No Coverage	None
If you are pregnant	Office visits	$90 Copayment per pregnancy	No Coverage	None
	Childbirth/delivery professional services	$100 Copayment per day; maximum of $300 per admission	No Coverage	None
	Childbirth/delivery facility services	$100 Copayment per day; maximum of $300 per admission	No Coverage	
If you need help recovering or have other special health needs	Home health care	0% Coinsurance after deductible	No Coverage	Services limited to 60 visits per Benefit Period.
	Rehabilitation services	$25 Copayment per visit regardless of provider type or location	No Coverage	Physical & Occupational Therapy – Services limited to 50 visits combined per Benefit Period. Must obtain authorization for additional visits.
	Habilitation services	$25 Copayment per visit regardless of provider	No Coverage	Physical & Occupational Therapy – Services limited to 50 visits combined per Benefit

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)	
		type or location		Period. Must obtain authorization for additional visits.
	Skilled nursing care	$100 Copayment per day; maximum of $300 per admission	No Coverage	Services limited to 90 days per Benefit Period.
	Durable Medical Equipment	20% Coinsurance of first $5,000 Allowable per Benefit Period (after deductible); 0% Coinsurance of Allowable in excess of $5,000 per Benefit Period (after deductible).	No Coverage	None
	Hospice services	0% Coinsurance after deductible	No Coverage	Services limited to 180 days per Benefit Period.
If your child needs dental or eye care	Children's eye exam	Routine - No Coverage	Routine - No Coverage	Not Covered
	Children's glasses	No Coverage	No Coverage	Not Covered
	Children's dental check-up	No Coverage	No Coverage	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.)

- Cosmetic Surgery
- Hearing Aids (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the United States from non-Blue Cross Blue Shield Global Core providers
- Private-Duty Nursing
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care (Some restrictions apply)
- Dental Care (Coverage is only available for Oral Surgery for Impacted Teeth)
- Glasses - Frames limited to a maximum benefit of $50. Must be purchased within 6 months following cataract surgery. Services are subject to the Benefit Period deductible and are available for all members.

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 .

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, 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	$400
Specialist *copayment*	$50
Hospital (facility) *copayment*	$100
Other *coinsurance*	0%

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:

Cost Sharing	
Deductibles	$400
Copayments	$290
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$750**

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

The plan's overall deductible	$400
Specialist *copayment*	$50
Hospital (facility) *copayment*	$100
Other *coinsurance*	0%

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	$140
Copayments	$1,030
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,230**

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

The plan's overall deductible	$400
Specialist *copayment*	$50
Hospital (facility) *copayment*	$100
Other *coinsurance*	0%

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	$360
Copayments	$430
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$790**

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, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@lablue.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries 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 Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.

   Section 1557 Coordinator
   In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
   Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
   Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
   Fax: (225) 298-7240
   Email: Section1557Coordinator@lablue.com

2. If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to **www.lablue.com/checkmyplan**.

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ພິການຫູ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں. ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583. سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کم‌شنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)