Coverage Period: 01/01/2025 - 12/31/2025

Coverage for: Single or Multi Plan Type: IND POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <a href="www.bcbsla.com">www.bcbsla.com</a> or call 1-800-495-2583. For general definitions of common terms, such as <a href="allowed amount">allowed amount</a>, <a href="balance billing">balance billing</a>, <a href="coinsurance">coinsurance</a>, <a href="copayment">copayment</a>, <a href="deductible">deductible</a>, <a href="provider">provider</a> or other <a href="underlined">underlined</a> terms see the <a href="Glossary">Glossary</a>.

You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary">www.healthcare.gov/sbc-glossary</a> or call 1-800-495-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes.	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.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Not Applicable.	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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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 Yo	ou Will Pay	
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP 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	No charge	No charge	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 <u>Provider</u> .
	Specialist Visit	No charge	No charge	None
	Preventive care/screening/immunization	No charge	No charge	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)	No charge	No charge	May be required to obtain authorization.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Must obtain authorization

		What Y	ou Will Pay	
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.bcbsla.com/pharmacy-2tier-formulary2025	Tier 1 - Typically Generic Drugs	No charge	No charge	This plan has a 2-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 prescription drug coverage is available at http://www.bcbsla.com/pharmacy-2tier-formulary2025.
	Tier 2 - Typically Preferred Brand Drugs	No charge	No charge	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3 - Typically Non- Preferred Brand Drugs	No charge	No charge	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4 - Typically Specialty Drugs	No charge	No charge	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Must obtain authorization. Failure to do so may result in a 30% penalty.
	Physician/Surgeon Fees	No charge	No charge	Must obtain authorization. Failure to do so may result in a 30% penalty.
If you need immediate	Emergency room care	No charge	No charge	Balance billing prohibited.
medical attention	Emergency medical transportation	No charge	No charge	What you will pay for OON emergency ambulance services may be less in some cases. Balance billing may be prohibited.
	Urgent care	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Must obtain authorization
	Physician/surgeon fees	No charge	No charge	None

		What You Will Pay		
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health or	Mental/Behavioral health outpatient services	No charge	No charge	May be required to obtain authorization.
substance abuse services	Mental/Behavioral health inpatient services	No charge	No charge	Must obtain authorization.
	Substance use disorder inpatient services	No charge	No charge	Must obtain authorization.
	Substance use disorder outpatient services	No charge	No charge	May be required to obtain authorization.
If you are pregnant	Office visits	No charge	No charge	None
	Childbirth/delivery professional services	No charge	No charge	May be required to obtain authorization.
	Childbirth/delivery facility services	No charge	No charge	May be required to obtain authorization.
If you need help recovering		No charge	No charge	Must obtain authorization
or have other special health needs	Rehabilitation services	No charge	No charge	None
liccus	Habilitation services	No charge	No charge	None
	Skilled nursing care	No charge	No charge	Must obtain authorization
	Durable medical equipment	No charge	No charge	May be required to obtain authorization
	Hospice services	No charge	No charge	Must obtain authorization

		What Y	ou Will Pay	
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP 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.

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

Additional information about Limitations and Exceptions: <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u>. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference (<u>balance billing</u>).

#### **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 <u>plan</u> document)

Chiropractic care	Non-emergency care when traveling outside the United	Private-Duty Nursing
Hearing aids	States	

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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u> or a <u>grievance</u> for any reason to your <u>plan</u>. 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:



**Total Example Cost** 

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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)

<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> </ul>	\$0
<ul> <li>Specialist coinsurance</li> </ul>	0%
<ul> <li>Hospital (facility) coinsurance</li> </ul>	0%
Other coinsurance	0%

#### 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)

In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$0	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
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)

<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> </ul>	\$0
• Specialist coinsurance	0%
<ul> <li>Hospital (facility) coinsurance</li> </ul>	0%
Other coinsurance	0%

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

\$12,700

**Total Example Cost** 

Durable medical equipment (*glucose meter*)

<u>-</u>			
In this example, Joe would pay:			
Cost Sharing			
Deductibles	\$0		
Copayments	\$0		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$60		
The total Joe would pay is	\$60		

#### Mia's Simple Fracture

(in-network emergency room and follow up care)

• The <u>plan's</u> overall <u>deductible</u>	\$0
• Specialist coinsurance	0%
<ul> <li>Hospital (facility) coinsurance</li> </ul>	0%
Other <u>coinsurance</u>	0%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (*x-ray*)

Total Evample Cost

\$5,600

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	<b>ΨΖ,000</b>			
In this example, Mia would pay:				
Cost Sharing				
Deductibles	\$0			
Copayments	\$0			
Coinsurance	\$0			
What isn't covered				
Limits or exclusions	\$0			
The total Mia would pay is	\$0			

42 800

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

# Nondiscrimination Notice

Discrimination is Against the Law

origin, age, disability or sex in its health programs or activities Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life

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

MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711). If you need these services, you can call the Customer Service number on the back of your ID card or email

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

5 If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. Cross or owned by your employer, go to www.bcbsla.com/checkmyplan. To determine if your plan is fully insured by Blue

Department of Health and Human Services, Office for Civil Rights by mail or phone at: Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S

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)

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http://www.hhs.gov/ocr/office/file/index.html. https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Electronically through the Office for Civil Rights Complaint Portal, available at Complaint forms are available at

## NOTICE

Hearing-impaired customers call 1-800-711-5519 (TTY 711). Free language services are available. If needed, please call the Customer Service number on the back of your ID card.

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).

figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711). Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle

Khách hàng nào bị suy giảm thính lực hãy gọi số 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

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-

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likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711). Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa

연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 모 에

verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711). Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ ೨ ກະລຸນາໂທຫາພະແນກບໍ ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711). ໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈາຕົວຂອງທ່ານ.

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 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。 ターの電話番

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 والےے کسٹمرز (TTY 711) 5519-711-580-1 پر کال کریں۔

der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an. Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf

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нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711) обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела

สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711) มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน