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 Employee: $0; Employee + 1: $0 or $0 family; 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 **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?	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 Employee: $2,000; Employee + 1: $3,000 or $4,000 family; 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**, 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/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	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		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 PBM.
	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 Plan Year	$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	No Coverage	None
If you need immediate medical attention	Emergency room care	Facility - $200 Copayment Non-Facility Charges – 0% Coinsurance	Facility - $200 Copayment Non-Facility Charges – 0% Coinsurance	Facility copayment waived if admitted to the same facility
	Emergency medical transportation	Ground-$50 Copayment per trip; Air-$250 Copayment per trip	Ground-$50 Copayment per trip; Air-$250 Copayment per trip	None
	Urgent care	$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 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	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	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 over the limit of 50 visits combined per Benefit Period.
	Habilitation 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

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)	
				additional visits over the limit of 50 visits combined per Benefit Period.
	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; 0% Coinsurance of Allowable in excess of $5,000 per Benefit Period	No Coverage	None
	Hospice services	0% Coinsurance	No Coverage	Services limited to 180 days per Benefit Period.
If your child needs dental or eye care	Children's eye exam	No Coverage	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 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	$0
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	$0
Copayments	$290
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$350**

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

The plan's overall deductible	$0
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	$0
Copayments	$1,030
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,090**

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

The plan's overall deductible	$0
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	$0
Copayments	$430
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$480**

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