**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**Coverage Period: 01/01/2027 - 12/31/2027**

**Blue Cross and Blue Shield of Louisiana: Blue Max Copay (PCP) 50/50 $3300 with 2 $0 PCP Virtual Visits**

**Coverage for:** Single or Multi **Plan Type:** IND PPO

**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.lablue.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 $3,300 individual or $9,900 family; for out-of-network providers $9,900 individual or $29,700 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?** | 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 $11,000 individual / $22,000 family; for out-of-network providers $33,000 individual / $66,000 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.lablue.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 † | 50% Coinsurance | On eligible plans, you may receive up to 2 $0 PCP Virtual Visits (includes PCP, Urgent Care, and Behavioral Health visits). |
| | Specialist Visit | $65 Copayment † | 50% Coinsurance | None |
| | Preventive care/screening/immunization | No charge. † | 50% 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.lablue.com/preventive.<br><br>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) | 50% Coinsurance | 50% Coinsurance | May be required to obtain authorization. |
| | Imaging (CT/PET scans, MRIs) | 50% Coinsurance | 50% 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.lablue.com/pharmacy-3tier-formulary2027** | Tier 1 - Typically Generic Drugs | $15 Copayment | $15 Copayment | This plan 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 prescription drug coverage, including the exceptions process, is available at http://www.lablue.com/pharmacy. |
| | Tier 2 - Typically Preferred Brand Drugs | 20% Coinsurance up to $500 per prescription | 20% Coinsurance up to $500 per prescription | See Drug Tier 1 Limitations, Exceptions, & Other Important Information. |
| | Tier 3 - Typically Non-Preferred Brand Drugs | 30% Coinsurance up to $500 per prescription | 30% Coinsurance up to $500 per prescription | See Drug Tier 1 Limitations, Exceptions, & Other Important Information. |
| | Tier 4 - Typically Specialty Drugs | 20% Coinsurance up to $500 per prescription | 20% Coinsurance up to $500 per prescription | See Drug Tier 1 Limitations, Exceptions, & Other Important Information. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% Coinsurance | 50% Coinsurance | None |
| | Physician/Surgeon Fees | 50% Coinsurance | 50% Coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 50% Coinsurance | 50% Coinsurance | For an emergency, call 911 or go to the nearest emergency room. Balance billing prohibited. |
| | Emergency medical transportation | 50% Coinsurance | 50% Coinsurance | What you will pay for OON emergency ambulance services may be less in some cases. Balance billing may be prohibited. |
| | Urgent care | $65 Copayment † | 50% Coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% Coinsurance | 50% Coinsurance | Must obtain authorization |
| | Physician/surgeon fees | 50% Coinsurance | 50% 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 50% Coinsurance other outpatient services | 50% Coinsurance | May be required to obtain authorization |
| | Mental/Behavioral health inpatient services | 50% Coinsurance | 50% Coinsurance | Must obtain authorization |
| | Substance use disorder inpatient services | 50% Coinsurance | 50% Coinsurance | Must obtain authorization |
| | Substance use disorder outpatient services | $40 Copayment † /office visit and 50% Coinsurance other outpatient services | 50% Coinsurance | May be required to obtain authorization |
| **If you are pregnant** | Office visits | $65 Copayment † /office visit | 50% Coinsurance | Cost sharing does not apply for qualifying preventive services. |
| | Childbirth/delivery professional services | 50% Coinsurance | 50% Coinsurance | None |
| | Childbirth/delivery facility services | 50% Coinsurance | 50% Coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 50% Coinsurance | 50% Coinsurance | Must obtain authorization |
| | Rehabilitation services | 50% Coinsurance | 50% Coinsurance | None |
| | Habilitation services | 50% Coinsurance | 50% Coinsurance | None |
| | Skilled nursing care | 50% Coinsurance | 50% Coinsurance | Must obtain authorization |
| | Durable medical equipment | 50% Coinsurance | 50% Coinsurance | May be required to obtain authorization |
| | Hospice services | 50% Coinsurance | 50% 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.

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---------- *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** | **$3,300** |
| • **Specialist copayment** | **$65** |
| • **Hospital (facility) coinsurance** | **50%** |
| • **Other coinsurance** | **50%** |

**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* | $3,310 |
| Copayments | $70 |
| Coinsurance | $3,330 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,770** |

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

| | |
|---|---|
| • **The plan's overall deductible** | **$3,300** |
| • **Specialist copayment** | **$65** |
| • **Hospital (facility) coinsurance** | **50%** |
| • **Other coinsurance** | **50%** |

**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 | $640 |
| Copayments | $490 |
| Coinsurance | $680 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,870** |

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

| | |
|---|---|
| • **The plan's overall deductible** | **$3,300** |
| • **Specialist copayment** | **$65** |
| • **Hospital (facility) coinsurance** | **50%** |
| • **Other coinsurance** | **50%** |

**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 | $2,420 |
| Copayments | $130 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,550** |

*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, 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**.


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# 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)