Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Coverage Period: 07/01/2024 - 06/30/2025
Blue Cross Blue Shield of Louisiana: Blue Saver 80/60 $1900
Coverage for: Multi **Plan Type:** GRP High Deductible

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 $1,900 individual or $3,800 family; for out-of-network providers $3,800 individual or $7,600 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 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.
What is the out-of-pocket limit for this plan?	For network providers $4,100 individual / $8,200 family; for out-of-network providers $8,200 individual / $16,400 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	20% Coinsurance	40% Coinsurance	None
	Specialist Visit	20% Coinsurance	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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network 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-formulary2024	Tier 1 - Typically Generic Drugs	20% Coinsurance	20% Coinsurance	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-formulary2024.
	Tier 2 - Typically Preferred Brand Drugs	40% Coinsurance	40% Coinsurance	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3 - Typically Non-Preferred Brand Drugs	40% Coinsurance	40% Coinsurance	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4 - Typically Specialty Drugs	40% Coinsurance	40% Coinsurance	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/Surgeon Fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Balance billing prohibited.
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	What you will pay for OON emergency ambulance services may be less in some cases. Balance billing may be prohibited.
	Urgent care	20% Coinsurance	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

		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 need mental health, behavioral health or substance abuse services	Mental/Behavioral health outpatient services	20% Coinsurance	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	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
If you are pregnant	Office visits	20% Coinsurance	40% Coinsurance	None
	Childbirth/delivery professional services	20% Coinsurance	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	20% Coinsurance	40% Coinsurance	None
	Habilitation services	20% Coinsurance	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
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- 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
- 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: 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 or 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? **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	$1,900
• Specialist coinsurance	20%
• 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	$1,900
Copayments	$0
Coinsurance	$2,140
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,100**

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

• The plan's overall deductible	$1,900
• Specialist coinsurance	20%
• 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	$1,900
Copayments	$0
Coinsurance	$440
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,400**

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

• The plan's overall deductible	$1,900
• Specialist coinsurance	20%
• 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	$1,900
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,080**

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