

**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: Group Care Copay 80/60 \$1000G****Coverage for:** Single or Multi **Plan Type:** GRP 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.bcbsla.com](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-495-2583 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For <u>network providers</u> \$1,000 individual or \$3,000 family; for <u>out-of-network providers</u> \$2,000 individual or \$6,000 family.	Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive Care</u> and <u>Wellness</u> are covered before you meet your <u>deductible</u> .	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost-sharing</b> and before you meet your <b>deductible</b> . See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For <u>network providers</u> \$5,250 individual / \$10,500 family; for <u>out-of-network providers</u> \$10,500 individual / \$21,000 family.	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>Balance Billing</u> Charges, and Health Care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.bcbsla.com">www.bcbsla.com</a> or call 1-800-495-2583 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <b>specialist</b> you choose without a <b>referral</b> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

†Deductible does not apply.

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	\$40 <u>Copayment</u> †	40% <u>Coinsurance</u>	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 or Affinity Health Group <u>Provider</u> .
	<u>Specialist Visit</u>	\$55 <u>Copayment</u> †	40% <u>Coinsurance</u>	If you have a <u>copayment plan</u> , the Specialist <u>copayment</u> may be reduced or waived when services are rendered by an Affinity Health Group <u>Provider</u> .
	<u>Preventive care/screening/immunization</u>	No charge. †	40% <u>Coinsurance</u> . †	Prostate Cancer <u>Screening</u> , Colorectal Cancer <u>Screening</u> , Flexible Sigmoidoscopy, Colonoscopy, Abdominal Aortic Aneurysm <u>Screening</u> , Mammography, Osteoporosis <u>Screening</u> , Routine Pap Smear, Autism <u>Screening</u> , Developmental <u>Screening</u> , Hearing <u>Screening</u> , Lead <u>Screening</u> , Tuberculosis <u>Screening</u> , Vision <u>Screening</u> . For more information about <u>Preventive Care &amp; Wellness</u> limitations and exceptions, see the brochure at <a href="https://www.bcbsla.com/preventive">https://www.bcbsla.com/preventive</a> .  You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic Test</u> (x-ray, blood work)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	May be required to obtain authorization.
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	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)	
<b>If you need drugs to treat your illness or condition</b> <b>More information about prescription drug coverage is available at</b> <a href="http://www.bcbsla.com/pharmacy-4tier-formulary2024">http://www.bcbsla.com/pharmacy-4tier-formulary2024</a>	Tier 1 - Typically Generic Drugs	\$7 <u>Copayment</u>	\$7 <u>Copayment</u>	This plan has a 4-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 <u>prescription drug coverage</u> is available at <a href="http://www.bcbsla.com/pharmacy-4tier-formulary2024">http://www.bcbsla.com/pharmacy-4tier-formulary2024</a> .
	Tier 2 - Typically Preferred Brand Drugs	\$30 <u>Copayment</u>	\$30 <u>Copayment</u>	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3 - Typically Non-Preferred Brand Drugs	\$70 <u>Copayment</u>	\$70 <u>Copayment</u>	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4 - Typically Specialty Drugs	10% <u>Coinsurance</u> up to \$150 per prescription	10% <u>Coinsurance</u> up to \$150 per prescription	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
	Physician/Surgeon Fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	<u>Balance billing</u> prohibited.
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	What you will pay for OON emergency ambulance services may be less in some cases. <u>Balance billing</u> may be prohibited.
	<u>Urgent care</u>	\$55 <u>Copayment</u> †	40% <u>Coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Must obtain authorization
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	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)	
<b>If you need mental health, behavioral health or substance abuse services</b>	Mental/Behavioral health outpatient services	\$40 <u>Copayment</u> † /office visit and 20% <u>Coinsurance</u> other outpatient services	40% <u>Coinsurance</u>	May be required to obtain authorization
	Mental/Behavioral health inpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Must obtain authorization
	Substance use disorder inpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Must obtain authorization
	Substance use disorder outpatient services	\$40 <u>Copayment</u> † /office visit and 20% <u>Coinsurance</u> other outpatient services	40% <u>Coinsurance</u>	May be required to obtain authorization
<b>If you are pregnant</b>	Office visits	\$55 <u>Copayment</u> † /office visit	40% <u>Coinsurance</u>	None
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	May be required to obtain authorization
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	May be required to obtain authorization
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Must obtain authorization
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Must obtain authorization
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	May be required to obtain authorization
	<u>Hospice services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Must obtain authorization
<b>If your child needs dental or eye care</b>	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 | • Infertility treatment | • Routine foot care    |
| • Cosmetic surgery  | • Long-term care        | • Weight Loss Programs |
| • Dental care       | • Routine eye care      |                        |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document)**

- |                     |   |                        |
|---------------------|---|------------------------|
| • Acupuncture       | • Hearing aids  | • Private-Duty Nursing |
| • Chiropractic care | • Non-emergency care when traveling outside the United 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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, kwijigo 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 **\$1,000**
- Specialist copayment **\$55**
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$2,010
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,080</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$1,000**
- Specialist copayment **\$55**
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$10
Copayments	\$1,300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,370</b>

**Mia's Simple Fracture**

(in-network emergency room and follow up care)

- The plan's overall deductible **\$1,000**
- Specialist copayment **\$55**
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$1,000
Copayments	\$120
Coinsurance	\$260
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,380</b>

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