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.erbenefits.com or call 225-922-5680. 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 1-800-363-9150 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,000 individual; for out-of-network providers $3,000 individual	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. $50 individual or $100 family for prescription drug coverage. 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 $6,900 individual / $13,800 family; for out-of-network providers $20,700 individual / $41,400 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	No.	You can see the **specialist** you choose without a **referral**.

see a specialist?		

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	$30 Copayment per visit	40% Coinsurance after deductible	None
	Specialist visit	$60 Copayment per visit	40% Coinsurance after deductible	None
	Other practitioner office visit	$60 Copayment per visit	40% Coinsurance after deductible	None
	Preventive care/screening/ immunization	No Cost	0% Coinsurance; deductible waived	Deductible is not applicable to preventive/wellness care.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	40% Coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsla.com	Tier 1	$10 Copayment retail; $25 Copayment mail order	30% Coinsurance after deductible (retail only)	Retail: 30-day supply Mail Order: 90-day supply Separate Prescription Drug Out-of-Pocket Maximum: $1,000 Person / $2,000 Family
	Tier 2	$25 Copayment retail; $65 Copayment mail order	30% Coinsurance after deductible (retail only)	Retail: 30-day supply Mail Order: 90-day supply Separate Prescription Drug Out-of-Pocket Maximum: $1,000 Person / $2,000 Family
	Tier 3	$45 Copayment retail; $100 Copayment mail order	30% Coinsurance after deductible (retail only)	Retail: 30-day supply Mail Order: 90-day supply Separate Prescription Drug Out-of-Pocket Maximum: $1,000 Person / $2,000 Family
	Tier 4	$45 Copayment retail; $100 Copayment mail order	30% Coinsurance after deductible (retail only)	Retail: 30-day supply Mail Order: 90-day supply Separate Prescription Drug Out-of-Pocket Maximum: $1,000 Person / $2,000 Family
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copayment per surgical visit then 20%	40% Coinsurance after deductible	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)	
		Coinsurance; deductible waived		
	Physician/surgeon fees	20% Coinsurance after deductible	40% Coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% Coinsurance after deductible	20% Coinsurance after deductible	None
	Emergency medical transportation	Ground: 20% Coinsurance after deductible Air: 20% Coinsurance after deductible	Ground: 40% Coinsurance after deductible Air: 20% Coinsurance after deductible	None
	Urgent care	$60 Copayment per visit	40% Coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 Copayment per admission then 20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in a $1,000 penalty and no benefit if not medically necessary.
	Physician/surgeon fees	20% Coinsurance after deductible	40% Coinsurance after deductible	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 outpatient services	Office Visits: $30 Copayment per visit; All Other Services: 20% Coinsurance after deductible	40% Coinsurance after deductible	Authorization may be required. Magellan Behavioral Health Services (1-800-991-5638) will administer benefits for all services.
	Mental/Behavioral inpatient services	$600 Copayment per admission then 20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in a $1,000 penalty and no benefit if not medically necessary. Magellan Behavioral Health Services (1-800-991-5638) will administer benefits for all services.
	Substance use disorder outpatient services	Office Visits: $30 Copayment per visit; All Other Services: 20% Coinsurance after deductible	40% Coinsurance after deductible	Authorization may be required. Magellan Behavioral Health Services (1-800-991-5638) will administer benefits for all services.
	Substance use disorder inpatient services	$600 Copayment per admission then 20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in a $1,000 penalty and no benefit if not medically necessary. Magellan Behavioral Health Services (1-800-991-5638) will administer benefits for all services.
If you are pregnant	Office visits	$30 Copayment per pregnancy	40% Coinsurance after deductible	Dependent maternity is not covered.
	Childbirth/delivery professional services	20% Coinsurance after deductible	40% Coinsurance after deductible	Authorization required if the mother's length of stay exceeds 48 hours following a vaginal delivery or 96 hours following a caesarean section.
	Childbirth/delivery facility services	$600 Copayment per admission then 20% Coinsurance after deductible	40% Coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	Rehabilitation services	20% Coinsurance after deductible Chiropractic Services:	40% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.

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)	
		$60 Copayment per visit		
	Habilitation services	20% Coinsurance after deductible Chiropractic Services: $60 Copayment per visit	40% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	Skilled nursing care	20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	Durable medical equipment	20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization (DME greater than $200). Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	Hospice services	20% Coinsurance after deductible	40% Coinsurance after deductible	Must obtain authorization.
If your child needs dental or eye care	Children's eye exam	$25 Copayment per visit	$35 Copayment per visit	Services must be performed by an optometrist, and are limited to one (1) exam in a 24 month period.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	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.)

- Acupuncture
- Bariatric Surgery (except for surgery and services related to surgery for morbid obesity)
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long-Term 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.)

- Chiropractic Care
- Hearing Aids
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing (Outpatient)
- Routine Eye Care

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 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	$1,000
Specialist *copayment*	$60
Hospital (facility) *copayment*	$600
Other *coinsurance*	20%

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	$1,010
Copayments	$1,230
Coinsurance	$380
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,680**

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*	$60
Hospital (facility) *copayment*	$600
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	$190
Copayments	$1,280
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,530**

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

The plan's overall deductible	$1,000
Specialist *copayment*	$60
Hospital (facility) *copayment*	$600
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	$1,010
Copayments	$120
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,410**

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