




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.ербenefits.com](http://www.ербenefits.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](http://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 <u>deductible</u> ?	For <u>network providers</u> \$600 individual; for <u>out-of-network providers</u> \$1,800 individual	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> and <u>Wellness</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes. \$50 individual or \$100 family for <u>prescription drug coverage</u> . There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$5,850 individual / \$11,700 family; for <u>out-of-network providers</u> \$17,550 individual / \$35,100 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.bcbsla.com">www.bcbsla.com</a> or call 1-800-495-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>Copayment</u> per visit	35% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$50 <u>Copayment</u> per visit	35% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Other practitioner office visit</u>	\$50 <u>Copayment</u> per visit	35% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No Cost	0% <u>Coinsurance</u> ; <u>deductible waived</u>	Deductible is not applicable to preventive/wellness care.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	Deductible is not applicable to X-rays, Lab Test, and Machine Tests when services are performed by a Network Physician or other Provider listed in the Copayment Services section.
	Imaging (CT/PET scans, MRIs)	15% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsla.com">http://www.bcbsla.com</a>	Tier 1	\$10 <u>Copayment</u> retail; \$25 <u>Copayment</u> mail order	30% <u>Coinsurance</u> after <u>deductible</u> (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 <u>Copayment</u> retail; \$65 <u>Copayment</u> mail order	30% <u>Coinsurance</u> after <u>deductible</u> (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 <u>Copayment</u> retail; \$100 <u>Copayment</u> mail order	30% <u>Coinsurance</u> after <u>deductible</u> (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 <u>Copayment</u> retail; \$100 <u>Copayment</u> mail	30% <u>Coinsurance</u> after <u>deductible</u> (retail only)	Retail: 30-day supply Mail Order: 90-day supply

Questions: Call 225-922-5680

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bcbsla.com](http://www.bcbsla.com) or [www.healthcare.gov](http://www.healthcare.gov) or call 1-800-363-9150 to request a copy.

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)	
		order		Separate Prescription Drug Out-of-Pocket Maximum: \$1,000 Person / \$2,000 Family
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$50 <u>Copayment</u> per surgical visit then 15% <u>Coinsurance</u> ; <u>deductible</u> waived	35% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization.
	Physician/surgeon fees	15% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	15% <u>Coinsurance</u> after <u>deductible</u>	15% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	Ground:15% <u>Coinsurance</u> after <u>deductible</u> Air:15% <u>Coinsurance</u> after <u>deductible</u>	Ground:35% <u>Coinsurance</u> after <u>deductible</u> Air:15% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	15% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$400 <u>Copayment</u> per admission then 15% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	Physician/surgeon fees	15% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	None

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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 outpatient services	Office Visits: \$25 <u>Copayment</u> per visit; All Other Services: 15% <u>Coinsurance</u> after deductible	35% <u>Coinsurance</u> after deductible	Authorization may be required. Magellan Behavioral Health Services (1-800-991-5638) will administer benefits for all services.
	Mental/Behavioral inpatient services	\$400 <u>Copayment</u> per admission then 15% <u>Coinsurance</u> after deductible	35% <u>Coinsurance</u> after deductible	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	Substance use disorder outpatient services	Office Visits: \$25 <u>Copayment</u> per visit; All Other Services: 15% <u>Coinsurance</u> after deductible	35% <u>Coinsurance</u> 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	\$400 <u>Copayment</u> per admission then 15% <u>Coinsurance</u> after deductible	35% <u>Coinsurance</u> after deductible	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
<b>If you are pregnant</b>	Office visits	\$25 <u>Copayment</u> per pregnancy	35% <u>Coinsurance</u> after deductible	Dependent maternity is not covered.
	Childbirth/delivery professional services	15% <u>Coinsurance</u> after deductible	35% <u>Coinsurance</u> 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	\$400 <u>Copayment</u> per admission then 15% <u>Coinsurance</u> after deductible	35% <u>Coinsurance</u> after deductible	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	15% <u>Coinsurance</u> after deductible	35% <u>Coinsurance</u> after deductible	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	<u>Rehabilitation services</u>	15% <u>Coinsurance</u> after deductible Chiropractic Services: \$50 <u>Copayment</u> per visit	35% <u>Coinsurance</u> after deductible	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	<u>Habilitation services</u>	15% <u>Coinsurance</u> after	35% <u>Coinsurance</u> after	Must obtain authorization. Failure to do so will

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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)	
		<u>deductible</u> Chiropractic Services: \$50 <u>Copayment</u> per visit	<u>deductible</u>	result in a 30% penalty and no benefit if not medically necessary.
	<u>Skilled nursing care</u>	15% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization (DME greater than \$200). Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
	<u>Hospice services</u>	15% <u>Coinsurance</u> after <u>deductible</u>	35% <u>Coinsurance</u> after <u>deductible</u>	Must obtain authorization. Failure to do so will result in a 30% penalty and no benefit if not medically necessary.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$30 <u>Copayment</u> per visit	\$30 <u>Copayment</u> 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

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## 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

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**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 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, kwijigo 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.*

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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 \$600
- Specialist copayment \$50
- Hospital (facility) copayment \$400
- Other coinsurance 15%

**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*)

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

<i>Cost Sharing</i>	
Deductibles	\$610
Copayments	\$830
Coinsurance	\$570
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,070</b>

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

- The plan's overall deductible \$600
- Specialist copayment \$50
- Hospital (facility) copayment \$400
- Other coinsurance 15%

**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:

<i>Cost Sharing</i>	
Deductibles	\$190
Copayments	\$1,220
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,470</b>

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

- The plan's overall deductible \$600
- Specialist copayment \$50
- Hospital (facility) copayment \$400
- Other coinsurance 15%

**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:

<i>Cost Sharing</i>	
Deductibles	\$610
Copayments	\$100
Coinsurance	\$440
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,150</b>