Coverage for: Individual & Family | Plan Type: EPO CORE



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 https://ebrschools.org/fiscalmanagement/businessoperations/benefits/ or call 225-922-5680. For general definitions of common terms, such as allowed amount, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u> or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://ebrschools.org/fiscalmanagement/businessoperations/benefits/ or call 225-922-5680. For general definitions of common terms, such as allowed amount, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u> or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://ebrschools.org/fiscalmanagement/businessoperations/benefits/ or call 225-922-5680. For general definitions of common terms, such as

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For narrow <u>network providers</u> \$1,000 individual / \$2,000 family; for <u>network providers</u> \$1,200 individual / \$2,400 family; for <u>out-of-network providers</u> \$3,600 individual / \$7,200 family	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 Wellness 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</u> <u>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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50 individual / \$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 <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For narrow network providers and network providers \$6,900 individual / \$13,800 family; for out-of-network providers \$20,700 individual / \$41,400 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>	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 <u>network provider</u> ?	Yes. See www.lablue.com or call 1-800-495-2583 for a list of network providers.	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</u> <u>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 see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies. The <u>deductible</u> does not apply when <u>copayments</u> are shown. <u>Copayments</u> are per visit.

			What You Will Pay		
Common Medical Event	Services You May Need	Narrow Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$0 / \$30 Copayment	\$40 <u>Copayment</u>	40% Coinsurance	Please refer to the Schedule of Benefits for select Network Providers that receive \$0 Copayment for services rendered.
If you visit a health	Specialist visit	\$60 Copayment	\$75 Copayment	40% Coinsurance	None
care <u>provider's</u> office or clinic	Other practitioner office visit	\$60 Copayment	\$75 <u>Copayment</u>	40% Coinsurance	None
	Preventive care/screening/ immunization	No Cost	No Cost	40% <u>Coinsurance</u>	None
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>Coinsurance</u>	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	X-Rays, Lab Tests and Machine Tests performed within the office, clinic, or independent lab of a Copay eligible Provider are covered at no cost.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	40% Coinsurance	Must obtain authorization.

			What You Will Pay		
Common Medical Event	Services You May Need	Narrow Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you would drawn to	Tier 1	\$10 <u>Copayment</u> retail; \$25 <u>Copayment</u> mail order	\$10 <u>Copayment</u> retail; \$25 <u>Copayment</u> mail order	30% Coinsurance	Dataile 20 day ayan ku Mail Ondan 00 day ayan ku
If you need drugs to treat your illness or condition More information about	Tier 2	\$25 <u>Copayment</u> retail; \$65 <u>Copayment</u> mail order	\$25 <u>Copayment</u> retail; \$65 <u>Copayment</u> mail order	30% Coinsurance	Retail: 30-day supply; Mail Order: 90-day supply Out-of-Network Mail Order is not covered. Separate Prescription Drug Deductible:
prescription drug coverage is available at https://www.express- scripts.com/	Tier 3	\$45 <u>Copayment</u> retail; \$100 <u>Copayment</u> mail order	\$45 <u>Copayment</u> retail; \$100 <u>Copayment</u> mail order	30% Coinsurance	\$50 Per Person / \$100 Family Separate Prescription Drug Out-of-Pocket: Maximum: \$1,000 Per Person / \$2,000 Family
	Tier 4	\$45 <u>Copayment</u> retail; \$100 <u>Copayment</u> mail order	\$45 <u>Copayment</u> retail; \$100 <u>Copayment</u> mail order	30% Coinsurance	Maximum. \$1,000 Fer Ferson / \$2,000 Family
If you have	Facility fee (e.g., ambulatory surgery center)	\$100 <u>Copayment</u> 20% <u>Coinsurance</u> <u>deductible</u> waived	\$150 <u>Copayment</u> 30% <u>Coinsurance</u> <u>deductible</u> waived	40% Coinsurance	Must obtain authorization.
outpatient surgery	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	40% Coinsurance	None
16	Emergency room care	20% Coinsurance	20% Coinsurance	20% Coinsurance	None
If you need immediate medical attention	Emergency medical transportation	20% Coinsurance	20% Coinsurance	20% Coinsurance	What you will pay for <u>out-of-network</u> emergency ground ambulance services may be less in some cases. <u>Balance billing</u> may be prohibited.
	Urgent care	\$60 Copayment	\$75 Copayment	40% Coinsurance	None
If you have a hospital	Facility fee (e.g., hospital room)	\$600 <u>Copayment</u> 20% <u>Coinsurance</u>	\$800 <u>Copayment</u> 30% <u>Coinsurance</u>	40% Coinsurance	Must obtain authorization.
stay	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	40% Coinsurance	None

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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.

	What You Will Pay					
Common Medical Event	Services You May Need	Narrow Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Mental/Behavioral outpatient services	Office Visits: \$0 / \$30 Copayment; All Other Services 20% Coinsurance	\$40 <u>Copayment</u>	40% Coinsurance	Authorization may be required. Please refer to the Schedule of Benefits for select Network Providers that receive \$0 Copayment for services rendered.	
If you need mental	Mental/Behavioral inpatient services	\$600 <u>Copayment</u> 20% <u>Coinsurance</u>	\$800 <u>Copayment,</u> 30% <u>Coinsurance</u>	40% Coinsurance	Must obtain authorization.	
health, or substance abuse services Substance use	disorder outpatient	Office Visits: \$0 / \$30 Copayment; All Other Services: 20% Coinsurance	\$40 <u>Copayment</u>	40% Coinsurance	Authorization may be required. Please refer to the Schedule of Benefits for select Network Providers that receive \$0 Copayment for services rendered.	
	Substance use disorder inpatient services	\$600 <u>Copayment</u> 20% <u>Coinsurance</u>	\$800 <u>Copayment</u> 30% <u>Coinsurance</u>	40% Coinsurance	Must obtain authorization.	
	Office visits	\$30 Copayment	\$40 Copayment	40% Coinsurance		
If you are pregnant	Childbirth/delivery professional services	20% Coinsurance	30% Coinsurance	40% Coinsurance	Dependent maternity is not covered.	
, , ,	Childbirth/delivery facility services	\$600 <u>Copayment</u> 20% <u>Coinsurance</u>	\$800 <u>Copayment</u> 30% <u>Coinsurance</u>	40% Coinsurance		
	Home health care	20% Coinsurance	30% Coinsurance	40% Coinsurance	Must obtain authorization. Limited to 75 visits.	
Marana and hada	Rehabilitation services	20% Coinsurance	30% Coinsurance	40% Coinsurance	Must obtain authorization.	
If you need help recovering or have	Habilitation services	20% Coinsurance	30% Coinsurance	40% Coinsurance	Must obtain authorization.	
other special health	Skilled nursing care	20% Coinsurance	30% Coinsurance	40% Coinsurance	Must obtain authorization. Limited to 60 visits.	
needs	Durable medical equipment	20% Coinsurance	30% Coinsurance	40% Coinsurance	Must obtain authorization for DME greater than \$200.	
	Hospice services	20% Coinsurance	30% Coinsurance	40% Coinsurance	Must obtain authorization. Limited to 180 days per lifetime.	

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.

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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.healthcare.gov or call 1-800-363-9150 to request a copy.

		What You Will Pay				
Common Medical Event	Services You May Need	Narrow Network Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Children's eye exam	\$20 Copayment	\$25 <u>Copayment</u>	\$35 <u>Copayment</u>	Limited to 1 eye exam performed by an optometrist every 24-months.	
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	
ucilial of eye cale	Children's dental check-up	Not Covered	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 (Services must be performed at a Blue Distinction Center + for Bariatric 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

Cosmetic Surgery

Hearing Aids

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

Questions: Call 225-922-5680 5 of 7

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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u> or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact HR, 1050 South Foster, Baton Rouge, LA 70806.

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.-

Questions: Call 225-922-5680 6 of 7

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>deductible</u>	\$1,000
■ Specialist copayment	\$60
■ Hospital (facility) <u>copayment</u>	\$600
■ Other <u>coinsurance</u>	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	\$1,100		
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 <u>deductible</u>	\$1,000
■ <u>Specialist</u> <u>copayment</u>	\$60
■ Hospital (facility) <u>copayment</u>	\$600
Other <u>coinsurance</u>	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	\$60
Copayments	\$1,160
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,280

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,000
■ Specialist copayment	\$60
■ Hospital (facility) <u>copayment</u>	\$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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,010
Copayments	\$120
Coinsurance	\$260
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,390

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.

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 253-495-170-1800. (خدمة الهاتف النصى 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: 750-495-110-800 (TTY 711) کی کمی کے شکار افراد اس نمبر پر کال کریں: 5519-801-100-11 (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 كمك زباني رايگان و ابزارهاي كمكي جانبي در دسترس هستند. در صورت نياز، لطفاً با «خدمات مشتريان» به شماره 2583-495-800-1 تماس بگيريد. مشتريان كمشنوا با 5519-711-800-1 (TTY 711) بگيرند.

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 (ТТҮ 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้า ที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)