OFFICE OF GROUP BENEFITS – MAGNOLIA LOCAL

Coverage Period: 01/01/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Plan Type: HMO

Coverage for: Active Employees and Retirees Without Medicare on or after March 1, 2015

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsla.com/ogb by calling **1-800-392-4089**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network Providers:** Employee: **$400**; Employee + 1: **$800**; Family: **$1,200**; Per Calendar Year **Non-Network Providers**: No Coverage	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event chart for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **Network Providers:** Employee: **$2,500**; Employee + 1: **$5,000**; Family: **$7,500**; Per Calendar Year **Non-Network Providers:** No Coverage	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance Billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Event chart describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a full listing of network providers, see www.bcbsla.com/ogb or call **1-800-392-4089.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Event chart for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Questions: Call **1-800-392-4089** or visit us at **www.bcbsla.com/ogb.**

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 or www.healthcare.gov or call 1-800-392-4089 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in Excluded Services & Other Covered Services. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Preferred **providers** by waiving or charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment per visit	No Coverage	None
	Specialist visit	$50 copayment per visit	No Coverage	None
	Other practitioner office visit	$25 copayment per visit	No Coverage	None
	Preventive care/screening	No Cost	No Coverage	Age and/or time restrictions apply
If you have a test	Diagnostic test (x-ray, blood work)	Office, Free Standing Independent Diagnostic Testing Facility, or Contracted Reference Lab: 0% coinsurance Outpatient Hospital: 0% coinsurance after deductible	No Coverage	None
	Imaging (CT/PET scans, MRIs)	$50 copayment per visit	No Coverage	Must obtain authorization.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsla.com/ogb or by calling (800)910-1831.	Generic Drugs ($30 Maximum per 30 day prescription, up to the $1,500 Out-of-Pocket Maximum per Person per Plan Year)	$0 after Maximum Out-of-Pocket is met	50% coinsurance –In State 80% coinsurance-Out of State	Appetite suppressant drugs; Dietary supplements; Topical forms of Minoxidil; Nutritional or parenteral therapy; Vitamins and minerals; Drugs available over the counter; medical foods; bulk chemicals; any federal legend drug with an over the counter equivalent available Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.
	Preferred Drugs ($55 Maximum per 30 day prescription, up to the $1,500 Out-of-Pocket Maximum per Person per Plan Year)	$20 after Maximum Out-of-Pocket is met	50% coinsurance –In State 80% coinsurance-Out of State	
	Non-Preferred Drugs and Specialty Drugs ($80 Maximum per 30 day prescription, up to the $1,500 Out-of-Pocket Maximum per Person per Plan Year)	$40 after Maximum Out-of-Pocket is met		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment per visit	No Coverage	Must obtain authorization.
	Physician/surgeon fees	0% coinsurance after deductible	No Coverage	None
If you need immediate medical attention	Emergency room services	Facility - $150 copayment Non-Facility Charges – 0% coinsurance after deductible	Facility - $150 copayment Non-Facility Charges – 0% coinsurance after deductible	Facility copayment waived if admitted
	Emergency medical transportation	Ground-$50 copayment per trip: Air-$250 copayment per trip	No Coverage	For emergency medical transportation only.
	Urgent care	$50 copayment per visit	No Coverage	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment per day; maximum of $300 per admission after deductible	No Coverage	Must obtain authorization.
	Physician/surgeon fee	0% coinsurance after deductible	No Coverage	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copayment per visit	No Coverage	Must obtain authorization for Intensive Outpatient Programs, Partial Hospitalization Programs, and services performed at Residential Treatment Centers.
	Mental/Behavioral health inpatient services	$100 copayment per day; Maximum of $300 per admission	No Coverage	Must obtain authorization.
	Substance use disorder outpatient services	$25 copayment per visit	No Coverage	Must obtain authorization for Intensive Outpatient Programs, Partial Hospitalization Programs, and services performed at Residential Treatment Centers.
	Substance use disorder inpatient services	$100 copayment per day; Maximum of $300 per admission	No Coverage	Must obtain authorization.
If you are pregnant	Prenatal and postnatal care	$90 copayment per pregnancy	No Coverage	None
	Delivery and all inpatient services	$100 copayment per day; Maximum of $300 per admission	No Coverage	Authorization may be required if the mother's length of stay exceeds 48 or 96 hours following a vaginal or caesarean delivery, respectively.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	No Coverage	Must obtain authorization. Services limited to 60 visits per plan year.
	Rehabilitation services	$25 copayment per visit regardless of provider type or location	No Coverage	Physical & Occupational Therapy – Must obtain Authorization for additional visits over the limit of 50 visits combined per year. Services performed by Licensed Massage Therapists are not covered.
	Habilitation services	$25 copayment per visit regardless of provider type or location	No Coverage	Physical & Occupational Therapy – Must obtain Authorization for additional visits over the limit of 50 visits combined per year. Services performed by Licensed Massage Therapists are not covered.
	Skilled nursing care	$100 copayment per day; Maximum of $300 per admission	No Coverage	Must obtain authorization. Services limited to 90 days per benefit period.
	Durable medical equipment	20% coinsurance of first $5,000 Allowable per year (after deductible); 0% coinsurance of Allowable in excess of $5,000 per year (after deductible).	No Coverage	Must obtain authorization for durable medical equipment, orthotic devices, and prosthetics greater than $300.
	Hospice service	0% coinsurance after deductible	No Coverage	Must obtain authorization. Services limited to 180 days per benefit period.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Coverage	No Coverage	Not Covered
	Glasses	Frames limited to a maximum benefit of $50	No Coverage	Purchased within 6 months following cataract surgery. Services are subject to the plan year deductible and are available for all members.
	Dental check-up	No Coverage	No Coverage	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Residential Treatment Centers
- Routine Eye Care
- Routine Foot Care (except for Diabetes)
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care (Some restrictions apply)
- Dental Care (Coverage is only available for Oral Surgery for Impacted Teeth)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-392-4089. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blue Cross and BlueShield of Louisiana at 1-800-599-2583 or www.bcbsla.com OR the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,677
- **Patient pays** $863

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Inpatient Medications	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$400
Co-pays	$313
Coinsurance	$0
Limits or exclusions	$150
Total	**$863**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,278
- **Patient pays** $2,122

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits	$250
Procedures	$450
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$400
Co-pays	$1,450
Coinsurance	$193
Limits or exclusions	$79
Total	**$2,122**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**.