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.la-umc.org 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 or call 1-800-363-9150 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers & out-of-network providers $0 individual or $0 family	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.
Are there other deductibles for specific services?	Yes. $200 individual or $400 family for prescription drug coverage. $25 for vision care 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 $0 individual & family; for out- of-network providers $0 individual & 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 see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

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	0% Coinsurance after deductible	0% Coinsurance after deductible	None
	Specialist visit	0% Coinsurance after deductible	0% Coinsurance after deductible	None
	Other practitioner office visit	0% Coinsurance after deductible	0% Coinsurance after deductible	None
	Preventive care/screening/ Immunization	No Cost	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance after deductible	0% Coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	0% Coinsurance after deductible	0% 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; $20 Copayment mail order	$10 Copayment retail; $20 Copayment mail order	Deductible must be satisfied before Coinsurance is applicable. Retail: 30-day supply Mail Order: 90-day supply
	Tier 2	$20 Copayment retail; $40 Copayment mail order	$20 Copayment retail; $40 Copayment mail order	Deductible must be satisfied before Coinsurance is applicable. Retail: 30-day supply Mail Order: 90-day supply
	Tier 3	$40 Copayment retail; $80 Copayment mail order	$40 Copayment retail; $80 Copayment mail order	Deductible must be satisfied before Coinsurance is applicable. Retail: 30-day supply Mail Order: 90-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance after deductible	0% 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)	
	Physician/surgeon fees	0% Coinsurance after deductible	0% Coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	0% Coinsurance after deductible	0% Coinsurance after deductible	None
	Emergency medical transportation	0% Coinsurance after deductible	0% Coinsurance after deductible	None
	Urgent care	0% Coinsurance after deductible	0% Coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance after deductible	0% Coinsurance after deductible	Must obtain authorization.
	Physician/surgeon fees	0% Coinsurance after deductible	0% Coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral outpatient services	0% Coinsurance after deductible	0% Coinsurance after deductible	Authorization may be required.
	Mental/Behavioral inpatient services	0% Coinsurance after deductible	0% Coinsurance after deductible	Must obtain authorization.
	Substance use disorder outpatient services	0% Coinsurance after deductible	0% Coinsurance after deductible	Authorization may be required.
	Substance use disorder inpatient services	0% Coinsurance after deductible	0% Coinsurance after deductible	Must obtain authorization.
If you are pregnant	Office visits	0% Coinsurance after deductible	0% Coinsurance after deductible	Dependent maternity is covered.
	Childbirth/delivery professional services	0% Coinsurance after deductible	0% 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	0% Coinsurance after deductible	0% Coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% Coinsurance after deductible	0% Coinsurance after deductible	Must obtain authorization.
	Rehabilitation services	0% Coinsurance after deductible	0% 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)	
	Habilitation services	0% Coinsurance after deductible	0% Coinsurance after deductible	Must obtain authorization.
	Skilled nursing care	0% Coinsurance after deductible	0% Coinsurance after deductible	Must obtain authorization.
	Durable medical equipment	0% Coinsurance after deductible	0% Coinsurance after deductible	Must obtain authorization for DME greater than $300.
	Hospice services	0% Coinsurance after deductible	0% Coinsurance after deductible	Must obtain authorization.
If your child needs dental or eye care	Children's eye exam	$25 deductible	$25 deductible	Services are limited to one (1) eye exam, per person, in any 12 month period.
	Children's glasses	Covered	Covered	Covered
	Children's dental check-up	Covered	Covered	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
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- 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
- 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$0
■ Specialist *coinsurance*	0%
■ Hospital (facility) *coinsurance*	0%
■ Other *coinsurance*	0%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$40
Copayments	$0
Coinsurance	$990
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$100**

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

■ The plan's overall deductible	$0
■ Specialist *coinsurance*	0%
■ Hospital (facility) *coinsurance*	0%
■ Other *coinsurance*	0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,020
Coinsurance	$0
What isn't covered	
Limits or exclusions	$90
The total Joe would pay is	**$1,310**

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

■ The plan's overall deductible	$0
■ Specialist *coinsurance*	0%
■ Hospital (facility) *coinsurance*	0%
■ Other *coinsurance*	0%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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