Louisiana

Galliano Marine Service, LLC

This 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 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, call **1-877-705-5427.** 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 **https://www.healthcare.gov/sbc-glossary** or **www.cciio.cms.gov** or call **1-877-705-5427** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$850** person/**$2,550** family. Out-of-Network **$850** person/**$2,550** family.	Generally, you must pay all 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. In-Network preventive care services 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 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. Prescription drug deductible **$50** person / **$100** family (Brand Name Drugs)	You have to meet a separate deductible for prescription drugs.
What is the out-of-pocket limit for this plan?	In-Network Medical **$3,100** person/**$5,100** family. Out-of-Network Medical **$6,200** person/**$10,900** family. Prescriptions: **$4,800** person / **$9,600** 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 services this plan does not 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.MyHealthToolkitLA.com** or call **1-800-810-BLUE (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
		In-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	$33 Copay/ visit Deductible does not apply	$33 Copay/ visit, deductible, then 30% Coinsurance	None
	Specialist visit	$50 Copay/ visit Deductible does not apply	$50 Copay/ visit, deductible, then30% Coinsurance	None
	Preventive care/screening/ immunization	No Charge	Not covered	Diagnostic Bone Density Screenings are covered with 50% Coinsurance. See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive..
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	30% Coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance, after deductible	30% Coinsurance, after deductible	Pre-authorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs (Retail)	30% ($25 min - $100 max)		RX Deductible (excluding Generics): $50 Single/$100 Family Non-Preferred: If a generic drug is prescribed and you request the brand medication, you will pay a penalty equal to the brand copay plus the difference between the brand and generic drug cost. Dispensing Limits: Retail: 30-daysupply Mail Order: 90-daysupply Specialty: 30-daysupply Diabetic: 90-daysuppl
	Generic drugs (Mail Order)	25% ($15 min - $200 max)		
	Preferred brand drugs (Retail)	35% ($35 min - $125 max) after RX deductible		
	Preferred brand drugs (Mail Order)	30% ($30 min - $250 max) after RX deductible		
	Non-preferred brand drugs (Retail)	40% ($50 min - $175 max) after RX deductible		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Mail Order)	35% ($45 min-$350 max) after RX deductible		
	Specialty drugs (Mail Order Only)	25% ($500 max) after RX deductible		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance, after deductible	30% Coinsurance, after deductible	Pre-authorization is required.
	Physician/surgeon fees	20% Coinsurance, after deductible	30% Coinsurance, after deductible	
If you need immediate medical attention	Emergency room care	$350 Copay/ visit, deductible, then20% Coinsurance	$350 Copay/ visit, deductible, then20% Coinsurance	Copayment will be waived if admitted.
	Emergency medical transportation	20% Coinsurance after deductible	30% Coinsurance	None
	Urgent care	$33 Copay/ visit	$33 Copay/ visit, deductible, then30% Coinsurance	In-Network Copay applies to the office visit only. All other services are covered with 20% Coinsurance. Out-of-Network Providers: members must pay the balance of the Provider's charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance, after deductible	30% Coinsurance, after deductible	Pre-authorization is required.
	Physician/surgeon fees	20% Coinsurance, after deductible	30% Coinsurance, after deductible	
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health and Substance abuse disorder-Office visit	$33 copay / visit Primary Care Physician $50 copay / visit Specialist	30% Coinsurance, after deductible	Pre-authorization is required.
	Mental/behavioral health and Substance abuse Outpatient services	20% Coinsurance, after deductible	30% Coinsurance, after deductible	
	Mental/behavioral health and Substance abuse Inpatient services	20% Coinsurance, after deductible	30% Coinsurance, after deductible	
	Mental/behavioral health & Substance abuse Emergency Room	$150 copay/visit, deductible, then 20% Coinsurance	$150 copay/visit, deductible, then 20% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$33 Copay/ visit	$33 Copay/ visit, deductible, then30% Coinsurance	Pre-authorization for facility services is required. Out-of-Network. In-Network Copay applies to the office visit only. All other office services ae covered with 20% Coinsurance In-Network and with 30% Coinsurance Out-of-Network. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% Coinsurance, after deductible	30% Coinsurance, after deductible	
	Childbirth/delivery facility services	20% Coinsurance, after deductible	30% Coinsurance, after deductible	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance, after deductible	30% Coinsurance, after deductible	100 visits/benefit year combined with Private Duty Nursing.Pre-authorization is required.
	Rehabilitation services	20% Coinsurance, after deductible	30% Coinsurance, after deductible	All rehabilitation services related to speech therapy, physical therapy and occupational therapy are limited to a combined sixty (60) visits per Member per Benefit Year. Pre-authorization is required.
	Habilitation services	20% Coinsurance, after deductible	30% Coinsurance, after deductible	All rehabilitation services related to speech therapy, physical therapy and occupational therapy are limited to a combined sixty (60) visits per Member per Benefit Year. Pre-authorization is required.
	Skilled nursing care	20% Coinsurance, after deductible	30% Coinsurance, after deductible	Admissions, limited to ninety (90) days per Member per Benefit Year. Pre-authorization is required.
	Durable medical equipment	20% Coinsurance, after deductible	30% Coinsurance, after deductible	Pre-authorization required. Hearing aids, for Members age seventeen (17) and under, limited to $1,400 per hearing aid and one (1) for each ear per Member per thirty-six (36) months
	Hospice services	20% Coinsurance, after deductible	30% Coinsurance, after deductible	Pre-authorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's dental check-up	Not Covered	Not Covered	See your Employer for benefit details.
	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	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
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Eye Care (Child)
- Gender Dysphoria and Gender Reassignment Surgery
- Infertility Treatment
- Long-Term Care
- Routine Eye Care (Adult)
- 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, limited to $1,000/benefit year
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing, if part of pre-authorized home health 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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa. 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 on how 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: 1-877-705-5427 or visit us at www.MyHealthToolkitLA.com, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

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 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: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng *customer service* na makikita sa unang pahina ng paunawang ito.

Chinese: 如需中文服务，请致电列于本通知首页的客户服务号码。

Navajo: T'áá Dinéjí shił hane'go shíká i'doolwoł nínízingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'igíí éí díí naaltsoos neiyi'nilígíí akáa'gi siłtsoozígíí bikáá' ííshjáąh.

———————————*To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next page.*———————————

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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	$850
Specialist Copayment	$50
Hospital (facility) Coinsurance	20%
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	$850
Copayments	$70
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,490**

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

The plan's overall deductible	$850
Specialist Copayment	$50
Hospital (facility) Coinsurance	20%
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	$100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,800**

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

The plan's overall deductible	$850
Specialist Copayment	$50
Hospital (facility) Coinsurance	20%
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	$850
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,360**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact:**1-877-705-5427.**

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

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید.
(Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)