CHOUEST GROUP HEALTH PLAN

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

Coverage Period: 01/01/2018 – 12/31/2018

Coverage for: Individual & Family | **Plan Type:** PORT/SHIPYARD PPO

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 by visiting www.chouest.com or by calling 1-985-601-4301.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network Providers:$690 Individual/ $2,070 Family Non-Network Providers:$690 Individual/ $2,070 Family; Per Calendar Year	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 chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Prescription Drug Deductible: $50 Person / $100 Family per Calendar year	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; Deductible does not apply to Generic Mail Order
Is there an out–of–pocket limit on my expenses?	Yes. Network Providers: $2,080 Individual/ $4,160 Family Non-Network Providers: $3,460 Individual/ $6,920 Family; Per Calendar Year	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. In and Out-of-Network limits are not integrated (combined).
What is not included in the out–of–pocket limit?	Premiums, Member Cost Share, Balance Billed Charges, Copays, deductibles 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 list of participating providers, see www.bcbsla.com or call 1-800-810-2583.	If you use an in-network doctor or 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 **providers** for 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 can see the **specialist** you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-985-601-4301

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 **healthcare.gov** or call 1-877-705-5427 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $25) 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 **in-network providers** by 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	$33 copay per visit	$33 copay; then 30% coinsurance after deductible	Labs, x-rays, injections, etc. are applied to the deductible
	Specialist visit	$33 copay per visit	$33 copay; then 30% coinsurance after deductible	Labs, x-rays, injections, etc. are applied to the deductible
	Other practitioner office visit Chiropractor and Psychiatrist	20% coinsurance after deductible	30% coinsurance after deductible	Labs, x-rays, injections, etc. are applied to the deductible
	Preventive care/screening/immunization	$33 copay per visit	$33 copay; then 30% coinsurance after deductible	----------None----------
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. Bone Mass Measurement: 50% after deductible	30% coinsurance after deductible Bone Mass Measurement: 50% after deductible	Must obtain authorization. All services that are payable at 50% and are never payable at 100%

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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 your **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$20 copayment retail; $5 copayment mail order	$25 copayment retail Not Covered – mail order	Deductible is not applicable for mail order only
	Preferred brand drugs	35% retail; 30% mail order (maximum $75 copayment retail; maximum $225 copayment mail order)	35% retail; (maximum $80 copayment retail)	Prescription drug deductible must be satisfied before copayments are applicable.
	Maintenance Medication Generic Preferred brand drugs	$5 copayment 30% (maximum $225 copayment)	Not Covered	Must be filled following Express Scripts Smart90 plan.
	Specialty drugs Accredo Pharmacy	10% ($75 minimum / $150 maximum) 25% ($500 maximum)	Not Covered	Prescription drug deductible must be satisfied before copayments are applicable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after deductible	30% Coinsurance after deductible	----------None----------
	Physician/surgeon fees	20% Coinsurance after deductible	30% Coinsurance after deductible	----------None----------
If you need immediate medical attention	Emergency room services	20% Coinsurance after deductible	30% Coinsurance after deductible	----------None----------
	Emergency medical transportation	20% Coinsurance after deductible	30% Coinsurance after deductible	Authorization required for non-emergency care.
	Urgent care	20% Coinsurance after deductible & $33 copayment	30% Coinsurance after deductible & $33 copayment	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in no benefit if not medically necessary.
	Physician/surgeon fee	20% Coinsurance after deductible	30% Coinsurance after deductible	----------None----------

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You can view the Glossary at www.bcbsla.com or healthcare.gov or call 1-877-705-5427 to request a copy.

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization for continuous services over three (3) hours.
	Mental/Behavioral health inpatient services	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in no benefit if not medically necessary.
	Substance use disorder outpatient services	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization for continuous services over three (3) hours.
	Substance use disorder inpatient services	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization. Failure to do so will result in no benefit if not medically necessary.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance after deductible	30% Coinsurance after deductible	Maternity benefits are available for Subscriber or Spouse only.
	Delivery and all inpatient services	20% Coinsurance after deductible	30% Coinsurance after deductible	Inpatient admission of more than 48 hours following routine vaginal deliveries required authorization. Inpatient admissions of more than 96 hours following cesarean section deliveries require 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 help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization. 100 visits per calendar year.
	Rehabilitation services	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization.
	Habilitation services	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization.
	Skilled nursing care	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization. 90 days following inpatient stay.
	Durable medical equipment	20% Coinsurance after deductible. C-PAP machines & related equipment: 50% after deductible	30% Coinsurance after deductible. C-PAP machines & related equipment: 50% after deductible	Must obtain authorization for DME greater than $300. All services that are payable at 50% and are never payable at 100%.
	Hospice service	20% Coinsurance after deductible	30% Coinsurance after deductible	Must obtain authorization.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	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
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term Care
- Routine Eye Care
- Routine Foot Care
- 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 (985) 601-4301.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.

You may also contact the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-599-2583**

———————————*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:** $7,340
- **Plan pays** $5,320
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,340**

Patient pays:

Deductibles	$690
Coinsurance	$1,330
Total	**$2,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,982
- **Patient pays** $1,418

Sample care costs:

Prescriptions(1 brand /1 generic)	$2,900
Diabetic Supplies (medical)	$1,300
Office Visits (3 visits)	$700
Diabetic Education	$300
Laboratory tests	$100
Preventive Care Copay	$100
Total	**$5,400**

Patient pays:

Deductibles	$740
Copays	$228
Coinsurance	$150
Limits or exclusions	$300
Total	**$1,418**

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**.