

HMOLA POS

Blue POS Copay 80/60 \$750A

Group Size: 51+



Effective January 1, 2019

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	\$750	\$1,500
Family Deductible	\$2,250	\$4,500
Per Member Deductible within a Family	\$750	\$1,500
Individual Out of Pocket Max*	\$4,000	\$8,000
Family Out of Pocket Max*	\$8,000	\$16,000
Per Member OOP Max within a Family*	\$4,000	\$8,000
Coinsurance	80%	60%
Durable Medical Equipment (DME) Coinsurance	80%	60%
Office Visits		
Primary Care Physician (PCP)	\$30 Co-pay per visit	Deductible then Coinsurance
Quality Blue Primary Care	\$15 Co-pay per visit	Deductible then Coinsurance
Specialist	\$45 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care	\$45 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	\$30 Co-pay per visit	Deductible then Coinsurance
Urgent Care	\$45 Co-pay per visit	Deductible then Coinsurance
Lab & Low Tech Imaging	Fully Covered	Deductible then Coinsurance
High Tech Imaging (Free-standing)	Deductible then Coinsurance	Deductible then Coinsurance
Preventive & Wellness Office Visit	Fully Covered	Deductible then Coinsurance
Inpatient Services		
Inpatient Hospital Admission (Co-pay plans: Co-pay per day, 3 day max)	Deductible then Coinsurance	Deductible then Coinsurance
Inpatient Professional Services	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Services		
Emergency Room (Waived if admitted)	\$350 Co-pay	
Outpatient Facility	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Professional	Deductible then Coinsurance	Deductible then Coinsurance
Physical, Speech, & Occupational Therapy**	\$30 Co-pay per visit	Deductible then Coinsurance
Lab and Low & High Tech Imaging	Deductible then Coinsurance	Deductible then Coinsurance
Other Covered Services		
Ambulance (Medically necessary)	\$50 Co-pay	Deductible then Coinsurance
Prosthetics & Orthotics	Deductible then DME Coinsurance	Deductible then Coinsurance
Durable Medical Equipment	Deductible then DME Coinsurance	Deductible then Coinsurance
Skilled Nursing Facility***	Deductible then Coinsurance	Deductible then Coinsurance
Home Health Care Services***	Deductible then Coinsurance	Deductible then Coinsurance
Hospice Care Services***	Deductible then Coinsurance	Deductible then Coinsurance
Organ & Tissue Transplant****	Deductible then Coinsurance	Not Covered
Prescription Medication		
Drug Deductible	None	
Tier 1: Value Drugs: Primarily Generic Drugs, some Brand-Name Drugs	\$7.00	\$21
Tier 2: Brand-Name Drugs	\$30.00	\$90
Tier 3: Primarily Brand-Name Drugs, some Generic Drugs, and Covered Compound Drugs	\$70.00	\$210
Tier 4: Specialty Drugs (Limited to a 30 day supply per fill)	Plan: 90%; Member: 10% Specialty with \$150 max	
<i>When a brand drug is dispensed and a generic equivalent exists, members are required to pay the Tier 1 copay, plus the difference in cost between the brand drug dispensed and its generic equivalent.</i>		

*All in-network medical and pharmacy deductibles, copayments and coinsurance apply to out-of-pocket max. A separate out-of-pocket max will apply for services received out-of-network.

**Provides coverage for inpatient, outpatient and professional services subject to the same deductible and coinsurance with no dollar limit.

***Services that require pre-authorization (This is a partial list, please see the schedule of benefits for complete list.)

****Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplant (BDCT) or a Blue Cross and Blue Shield of Louisiana (BCBSLA) Preferred Provider facility, unless otherwise approved by us in writing. Services require pre-authorization.

This is only an outline. All benefits are subject to the terms and conditions of the Contract. In the case of a discrepancy, the Contract will prevail.