

HMOLA POS



Blue POS Copay 100/70
(Modified O.O.P and Rx Card)

Archdiocese of New Orleans
Effective July 1, 2017

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	None	\$1,000
Family Deductible	None	\$3,000
Individual Out of Pocket Max*	\$3,000	\$5,000
Family Out of Pocket Max*	\$6,000	\$10,000
Coinsurance	100%	70%
Durable Medical Equipment (DME) Coinsurance	80%	70%
Office Visits		
Primary Care Physician (PCP)	\$20 Co-pay per visit	Deductible then Coinsurance
Quality Blue Primary Care	\$5 Co-pay per visit	N/A
Specialist	\$35 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care	\$35 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	\$20 Co-pay per visit	Deductible then Coinsurance
Urgent Care	\$35 Co-pay per visit	Deductible then Coinsurance
Lab & Low Tech Imaging	Fully Covered	Deductible then Coinsurance
High Tech Imaging (Free-standing)	Fully Covered	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)	\$200 Co-pay	Deductible then Coinsurance
Inpatient Professional Services	In-Network Coinsurance	Deductible then Coinsurance
Outpatient Services		
Emergency Room (Waived if admitted)	\$350 Co-pay	
Outpatient Facility	\$200 Co-pay	Deductible then Coinsurance
Outpatient Professional	In-Network Coinsurance	Deductible then Coinsurance
Physical, Speech, and Occupational Therapy**	\$20 Co-pay per visit	Deductible then Coinsurance
Lab and Low & High Tech Imaging	Fully Covered	Deductible then Coinsurance
Other Covered Services		
Ambulance (Medically necessary)	\$50 Co-pay	Deductible then Coinsurance
Prosthetics & Orthotics	DME Coinsurance	Deductible then Coinsurance
Durable Medical Equipment	DME Coinsurance	Deductible then Coinsurance
Skilled Nursing Facility***	In-Network Coinsurance	Deductible then Coinsurance
Home Health Care Services***	In-Network Coinsurance	Deductible then Coinsurance
Hospice Care Services***	In-Network Coinsurance	Deductible then Coinsurance
Organ & Tissue Transplant****	In-Network Coinsurance	Not Covered
Prescription Medication		
	Retail Copayment	Mail Copayment
Drug Deductible	\$100 Separate Drug Deductible - \$200 Family Max. Applies to Brand Products Only	
Generic Drugs	\$7	\$21
Preferred Brand Drugs	\$30	\$90
Non-Preferred Brand	\$70	\$210
Specialty (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 generic 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.