Preferred Care

Group Care Copay 80/60 $500
(Modified O.O.P. and Rx Card)

Archdiocese of New Orleans
Effective July 1, 2017

Your Covered Benefits Are:	Network	Out of Network
Individual Deductible	$500	$1,000
Family Deductible	$1,500	$3,000
Individual Out of Pocket Max*	$2,750	$5,500
Family Out of Pocket Max*	$5,500	$11,000
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	N/A
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 and Wellness	Fully Covered	Out of Network Coinsurance
Inpatient Services		
Inpatient Hospital Admission	Deductible then Coinsurance	Deductible then Coinsurance
Inpatient Professional Services	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Services		
Emergency Room (Waived if admitted)	In-Network Deductible then Coinsurance	
Outpatient Facility	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Professional	Deductible then Coinsurance	Deductible then Coinsurance
Physical, Speech & Occupational Therapy **	Deductible then Coinsurance	Deductible then Coinsurance
Lab and Low & High Tech Imaging	Deductible then Coinsurance	Deductible then Coinsurance
Other Covered Services		
Ambulance (Medically necessary)	Deductible then Coinsurance	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	**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	
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.		

*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.