Group Blue Connect Acadiana POS

Blue Connect Acadiana POS Copay 100/70

Group Size: 50 or less **Effective January 1, 2017**

HMO Louisiana

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	None	$1,000
Family Deductible	None	$3,000
Individual Out of Pocket Max*	$2,000	$4,000
Family Out of Pocket Max*	$4,000	$8,000
Coinsurance	100%	70%
Durable Medical Equipment (DME) Coinsurance	80%	70%
Office Visits		
Primary Care Physician (PCP)	$35 Co-pay per visit	Deductible then Coinsurance
Quality Blue Primary Care	$0 Co-pay per visit	N/A
Specialist	$50 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care	$50 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	PCP Co-pay waived	Deductible then Coinsurance
Urgent Care	$50 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 and 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**	$35 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
Pediatric Vision & Dental	Routine eye exam & hardware and diagnostic & preventive dental are covered at 100% in-network	
Prescription Medication	**Retail Copayment**	**Mail Copayment**
Drug Deductible	None	
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.