Preferred Care

Group Care Copay 70/50 $3500D

Group Size: 51+

Effective January 1, 2019

Louisiana

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	$3,500	$7,000
Family Deductible	$10,500	$21,000
Per Member Deductible within a Family	$3,500	$7,000
Individual Out of Pocket Max*	$6,350	$12,700
Family Out of Pocket Max*	$12,700	$25,400
Per Member OOP Max within a Family*	$6,350	$12,700
Coinsurance	70%	50%
Durable Medical Equipment (DME) Coinsurance	70%	50%
Office Visits		
Primary Care Physician (PCP)	$40 Co-pay per visit	Deductible then Coinsurance
Quality Blue Primary Care	$25 Co-pay per visit	Deductible then Coinsurance
Specialist	$55 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care	$55 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	$40 Co-pay per visit	Deductible then Coinsurance
Urgent Care	$55 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 (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)	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	None	
Tier 1: Value Drugs: Primarily Generic Drugs, some Brand-Name Drugs	$15.00	$45
Tier 2: Brand-Name Drugs	$40.00	$120
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	

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.

*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.