2019 OPPJ - Blue Cross Blue Shield – Benefit Summary

Quality Blue Primary Care Co-Pay	$ 5 co-pay
Primary Care Physician Co-Pay	$15 co-pay
Specialist Physician Co-Pay	$45 co-pay
Wellness/Preventative Services	$0 co-pay
Pharmacy Co-Pays	$7/$30/$70
Specialty Pharmacy Prescription	10% Co-insurance
Yearly Deductible	$ 0
In-Patient Hospitalization Co-Pay (Per Day, 3 Day Max)	$250 co-pay
Out-Patient Procedure Co-Pay	$300 co-pay
Major Diagnostic Test Co-Pay MRI, Cat Scan, Pet Scan)	$250 co-pay
Emergency Room Co-Pay	$350 co-pay
Urgent Care Co-Pay (Such as St. Francis Urgent Care on Tower Dr)	$40 co-pay
Durable Medical Equipment	20% Co-insurance
Ambulance	$50 co-pay
Chemo/Radiation, Dialysis	20% Co-insurance
Out Of Pocket Maximum	$3,000/$6000

(ALL Co-Pays, prescription co-pays and co-insurance apply to the MAX Out Of Pocket)

NATIONWIDE NETWORK

Premier Blue

Louisiana

Premier Blue Copay 100/60 (M)

Group Size: 51+ **Effective January 1, 2019**

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	None	$5,000
Family Deductible	None	$10,000
Per Member Deductible within a Family	None	$5,000
Individual Out of Pocket Max*	$3,000	$10,000
Family Out of Pocket Max*	$6,000	$20,000
Per Member OOP Max within a Family*	$3,000	$10,000
Coinsurance	100%	60%
Durable Medical Equipment (DME) Coinsurance	80%	60%
Office Visits		
Primary Care Physician (PCP)	$15 Co-pay per visit	Deductible then Coinsurance
Quality Blue Primary Care	$5 Co-pay per visit	Deductible then Coinsurance
Specialist	$45 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care	$40 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	$15 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)	Fully Covered	Deductible then Coinsurance
Preventive and Wellness	Fully Covered	Deductible then Coinsurance
Inpatient Services		
Inpatient Hospital Admission (Co-pay plans: Co-pay per day, 3 day max)	$250 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	$300	Deductible then Coinsurance
Outpatient Professional	In-Network Coinsurance	Deductible then Coinsurance
Physical, Speech & Occupational Therapy**	$25 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	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 $150.00 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.