OPPJ / Blue Cross and Blue Shield 2021 benefit summary

- **$0 Co-Pay for Wellness/Preventative Services**
- **$10 Primary Quality Blue Provider co-Pay**
- **$25 Primary Care Provider Co-Pay**
- **$40 Specialty Care Provider Co-Pay**
- **$0 Co-pay X-Rays/Imaging in Dr Office**
- **$7/35/70 Pharmacy Co-Pay**

- **$500 Individual Deductible**
- **10% Co-Insurance Inpatient Hospitalization/Surgery***
- **10% Co-Insurance Procedures/Surgery***
- **10% Co-Insurance Major Medical Testing***
  (CAT, MRI, PET)

- **$350 Co-Pay Emergency Room**
- **$40 Urgent Care Co-Pay**
- **$25 Co-Pay PT/OT/Speech Therapy**

- **10% Co-Insurance chemo/radiation***
- **20% Co-Insurance Durable Medical Equipment***
- **10% Co-Insurance Dialysis/Home Health/Hospice***
- **NATIONWIDE NETWORK**
- **MAX OUT OF POCKET $3,250/$6,500**
  (Includes all co-pays/co-insurance)

***Co-Insurance After Deductible**

Louisiana

Effective January 1, 2021

Premier Blue

Premier Blue Copay 90/70 $500A
Group Size: 51+

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	$500	$1,000
Family Deductible	$1,500	$3,000
Individual Out of Pocket Max*	$3,250	$6,500
Family Out of Pocket Max*	$6,500	$13,000
Coinsurance	90%	70%
Durable Medical Equipment (DME) Coinsurance	80%	70%
Creditable Coverage	Creditable	
Office Visits		
Primary Care Physician (PCP)	$25 Co-pay per visit	Deductible then Coinsurance
Quality Blue Primary Care	$10 Co-pay per visit	Deductible then Coinsurance
Specialist	$40 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care	$40 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	$25 Co-pay per visit	Deductible then Coinsurance
Urgent Care	$40 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	Deductible then 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)	$350 Co-pay	
Outpatient Facility	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Professional	Deductible then Coinsurance	Deductible then Coinsurance
Physical, Speech & Occupational Therapy**	$25 Co-pay per visit	Deductible then Coinsurance
Lab and Low & High Tech Imaging	Deductible then Coinsurance	Deductible then Coinsurance
Other Covered Services		
Ambulance (Medically necessary)	$50 Co-pay	Deductible then Coinsurance
Prosthetics & Orthotics	Deductible then DME Coinsurance	Deductible then Coinsurance
Skilled Nursing Facility*** (Co-pay plans: Co-pay per day, 3 day max)	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	$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 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.