

OPPJ / Blue Cross and Blue Shield 2021 benefit summary

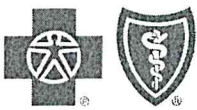
- \$0 Co-Pay for Wellness/Preventative Services
- \$10 Primary Quality Blue Provider co-Pay
- \$25 Primary Care Provider Co-Pay
- \$40 Specialty Care Provider Co-Pay
- \$0 Co-pay X-Rays/Imaging in Dr Office
- \$7/35/70 Pharmacy Co-Pay

- \$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		
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	
<i>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.</i>		

*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.

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company.