East Baton Rouge Parish School System

Buy Up HMO/POS

HMO Louisiana

January 1, 2021

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	$600	$1,800
Family Deductible	N/A	N/A
Per Member Deductible within a Family	$600	$1,800
Individual Out of Pocket Max*	$5,850	$17,550
Family Out of Pocket Max*	$11,700	$35,100
Per Member OOP Max within a Family*	$5,850	$17,550
Coinsurance	85% / 15%	65% / 35%
Office Visits		
Primary Care Physician (PCP)	$25 Co-pay per visit	Deductible then Coinsurance
Specialist	$50 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care (Physicians services only)	$25 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	$25 Co-pay per visit	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)	Deductible then Coinsurance	Deductible then Coinsurance
Preventive and Wellness	Fully Covered	Fully Covered
Inpatient Services		
Inpatient Hospital Admission (Copay is in addition to the Ded. Amount and the Ded. Amount is not reduced by the Copayment.)	$400 Co-pay per Admission, Deductible then Coinsurance	Deductible then Coinsurance
Inpatient Professional Services	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Services		
Emergency Room	Deductible then 85% / 15% Coinsurance	
Outpatient Facility	$50 Co-pay per visit, then Coinsurance, deductible waived	Deductible then Coinsurance
Outpatient Professional	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 Coinsurance	Deductible then Coinsurance
Physical, Speech, & Occupational Therapy	Deductible then Coinsurance	Deductible then Coinsurance
Durable Medical Equipment	Deductible then 80% / 20% Coinsurance	Deductible then Coinsurance
Skilled Nursing Facility*** (60 days per benefit period)	Deductible then Coinsurance	Deductible then Coinsurance
Home Health Care Services*** (75 visits per benefit period)	Deductible then Coinsurance	Deductible then Coinsurance
Hospice Care Services*** (180 days Lifetime max.)	Deductible then Coinsurance	Deductible then Coinsurance
Organ & Tissue Transplant****	Deductible then Coinsurance	Not Covered
Vision Care Exam 1 exam in a 24-month period (Optometrist Only)	$30 Co-pay per visit	$30 Co-pay per visit

*All in-network medical and 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.