



January 1, 2021

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	\$1,000	\$3,000
Family Deductible	N/A	N/A
Per Member Deductible within a Family	\$1,000	\$3,000
Individual Out of Pocket Max*	\$6,900	\$20,700
Family Out of Pocket Max*	\$13,800	\$41,400
Per Member OOP Max within a Family*	\$6,900	\$20,700
Coinsurance	80% / 20%	60% / 40%
<b>Office Visits</b>		
Primary Care Physician (PCP)	\$30 Co-pay per visit	Deductible then Coinsurance
Specialist	\$60 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care (Physician Services Only)	\$30 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	\$30 Co-pay per visit	Deductible then Coinsurance
Urgent Care	\$60 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
<b>Inpatient Services</b>		
Inpatient Hospital Admission (Copay is in addition to the Ded. Amount and the Ded. Amount is not reduced by the Copayment.)	\$600 Co-pay per Admission, Deductible then Coinsurance	Deductible then Coinsurance
Inpatient Professional Services	Deductible then Coinsurance	Deductible then Coinsurance
<b>Outpatient Services</b>		
Emergency Room	Deductible then 80% / 20% Coinsurance	
Outpatient Facility	\$100 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
<b>Other Covered Services</b>		
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 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)	\$25 Co-pay per visit	\$35 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.