Blue POS

Blue Point of Service Co-pay 100/70 (Modified)

Archdiocese of New Orleans

Effective July 1, 2016

	Network	Non-Network
Benefit Period Deductible	None	$1,000 Single / $3,000 Family
***Out-of-Pocket Maximum	$3,000 Single / $6,000 Family	$5,000 Single / $10,000 Family
Coinsurance	100/0%	70/30%
Office Visits		
Physician/Specialist Office Visit	$20 / $35 Co-pay per visit	Deductible then Coinsurance
Quality Blue Primary Care (QBPC)	$5 Primary Care Co-pay per visit	N/A
Pregnancy Care Office Visit (See inpatient services for separate delivery charges)	$35 Co-pay	Deductible then Coinsurance
Mental, Nervous and Substance Abuse Office Visit	$20 Co-pay per visit	Deductible then Coinsurance
Urgent Care	$35 Co-pay per visit	Deductible then Coinsurance
Lab & Low Tech Imaging (Independent Lab or Free- Standing Imaging)	Plan pays 100%	Deductible then Coinsurance
High Tech Imaging Services (Free-Standing Imaging)	Plan pays 100%	Deductible then Coinsurance
Preventive and Wellness Service		
Preventive/Wellness Office Visits	Plan pays 100%	Deductible then Coinsurance
Inpatient Services		
Hospital Admission	$200 Co-pay per day (3 day max)	Deductible then Coinsurance
Physician Services	Plan pays 100%	Deductible then Coinsurance
Outpatient Services		
Emergency Room Coverage (waived if admitted)	$350 Co-pay	$350 Co-pay
Outpatient Facility	$200 Co-pay per visit	Deductible then Coinsurance
Outpatient Physician Services	Plan pays 100%	Deductible then Coinsurance
Physical, Speech, and Occupational Therapy	$20 Co-pay per visit	Deductible then Coinsurance
Lab, Low, and High Tech Imaging	Plan pays 100%	Deductible then Coinsurance
Other Covered Services		
Ambulance (when medically necessary)	$50 Co-pay	Deductible then Coinsurance
Prosthetics & Orthotics	Plan pays 100%	Deductible then Coinsurance
*Skilled Nursing Facility (90 days per benefit period)	Plan pays 100%	Deductible then Coinsurance
*Home Health Care Services (60 days per benefit period)	Plan pays 100%	Deductible then Coinsurance
*Hospice Care Services (180 days per benefit period)	Plan pays 100%	Deductible then Coinsurance
**Organ & Tissue Transplant (Authorization is required)	Plan pays 100%	Not Covered

Prescription Drugs : $100 Separate drug deductible - $200 per family max. Deductible applies to Brand products only.

Tier	Description	Retail Copayment	Mail Copayment
1	Generic drugs	$7	$21
2	Preferred Brand drugs	$30	$90
3	Non-Preferred drugs	$70	$210
4	Specialty drugs (Limited to a 30 day supply per fill)	10% spec with $150 max	10% spec with $150 max

*Services that require pre-authorization (This is a Partial list; please see the schedule of benefits for completed list).

**Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) or a Blue Cross and Blue Shield of Louisiana (BCBSLA) Preferred Provider facility, unless otherwise approved by us in writing.

***All in-network medical and pharmacy deductibles, copayments and coinsurance apply to the out-of-pocket max. A separate out-of-pocket max will apply for services received out-of-network.

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.