Group Care

Group Care PPO Co-pay 80/60 $500 (Modified Rx Card)

Archdiocese of New Orleans

Effective July 1, 2016

	Network	Non-Network
Benefit Period Deductible	$500 Single / $1,500 Family	$1,000 Single / $3,000 Family
****Out-of-Pocket Maximum	$2,750 Single / $5,500 Family	$5,500 Single/ $11,000 Family
Coinsurance	80%	60%
Office Visits		
Primary Care Physician/Specialist Office Visit	$30 / $45 Co-pay per visit	Deductible then Coinsurance
Quality Blue Primary Care (QBPC)	$15 Primary Care Co-pay per visit	N/A
Mental, Nervous and Substance Abuse Office Visit	$30 Co-pay per visit	Deductible then Coinsurance
Urgent Care	$45 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)	Deductible then Coinsurance	Deductible then Coinsurance
Preventive and Wellness Service		
Preventive/Wellness Office Visits	Plan pays 100%	Deductible then Coinsurance
Inpatient Services		
Hospital Admission	Deductible then Coinsurance	Deductible then Coinsurance
Physician Services	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Services		
Emergency Room Coverage (waived if admitted)	Deductible then Coinsurance	In-Network Deductible then Coinsurance
Outpatient Facility	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Physician Services	Deductible then Coinsurance	Deductible then Coinsurance
*Physical, Speech, and Occupational Therapy	Deductible then Coinsurance	Deductible then Coinsurance
Lab, Low, and High Tech Imaging	Deductible then Coinsurance	Deductible then Coinsurance
Other Covered Services		
Ambulance (when medically necessary)	Deductible then Coinsurance	Deductible then Coinsurance
Prosthetics & Orthotics	Deductible then Coinsurance	Deductible then Coinsurance
**Skilled Nursing Facility (90 days per benefit period)	Deductible then Coinsurance	Deductible then Coinsurance
**Home Health Care Services (60 days per benefit period)	Deductible then Coinsurance	Deductible then Coinsurance
**Hospice Care Services (180 days per benefit period)	Deductible then Coinsurance	Deductible then Coinsurance
***Organ & Tissue Transplant (Authorization is required)	Deductible then Coinsurance	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	Value 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

*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 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.