HMO Louisiana

Option 1

Effective 2025

HMOLA HMO

HMO Copay 80 $1000 (M) 78T68ERC

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	$1,000	None
Family Deductible	$3,000	None
Per Member Deductible within a Family	$1,000	None
Individual Out of Pocket Max*	$6,000	None
Family Out of Pocket Max*	$9,500	None
Per Member OOP Max within a Family*	$4,750	None
Coinsurance	80%	None
Durable Medical Equipment (DME) Coinsurance	80%	None
Office Visits		
Primary Care Physician (PCP)	$35 Co-pay per visit	Not Covered
Quality Blue Primary Care	$20 Co-pay per visit	Not Covered
Specialist	$50 Co-pay per visit	Not Covered
Pregnancy Care	$50 Co-pay	Not Covered
Mental & Nervous/Alcohol & Drug	$35 Co-pay per visit	Not Covered
Urgent Care	$50 Co-pay per visit	Not Covered
Lab & Low Tech Imaging	Fully Covered	Not Covered
High Tech Imaging (Free-standing)	Deductible then Coinsurance	Not Covered
Preventive and Wellness Office Visit	Fully Covered	Not Covered
Inpatient Services		
Inpatient Hospital Admission (Co-pay plans: Co-pay per day, 3 day max)	Deductible then Coinsurance	Not Covered
Inpatient Professional Services	Deductible then Coinsurance	Not Covered
Outpatient Services		
Emergency Room (Waived if admitted)	$350 Co-pay	
Outpatient Facility	Deductible then Coinsurance	Not Covered
Outpatient Professional	Deductible then Coinsurance	Not Covered
Physical, Speech & Occupational Therapy**	$35 Co-pay per visit	Not Covered
Lab and Low & High Tech Imaging	Deductible then Coinsurance	Not Covered
Other Covered Services		
Ambulance (Medically necessary)	$50 Co-pay	Not Covered
Prosthetics & Orthotics	Deductible then DME Coinsurance	Not Covered
Durable Medical Equipment	Deductible then DME Coinsurance	Not Covered
Skilled Nursing Facility***	Deductible then Coinsurance	Not Covered
Home Health Care Services***	Deductible then Coinsurance	Not Covered
Hospice Care Services***	Deductible then Coinsurance	Not Covered
Organ & Tissue Transplant****	Deductible then Coinsurance	Not Covered

- *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.
- **If the plan has PT/OT/ST copay, it is applicable to services performed in an in-network office or outpatient setting. Deductible coinsurance applies in an inpatient setting. If the plan does not have PT/OT/ST copay, deductible coinsurance applies in all settings.
- ***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.