



Your Covered Benefits Are:	Network		Non-Network
Individual Deductible	None		None
Family Deductible	None		None
Individual Out of Pocket Max*	\$3,250		None
Family Out of Pocket Max*	\$6,500		None
Coinsurance	90%		None
Durable Medical Equipment (DME) Coinsurance	80%		None
Creditable Coverage+	Creditable		
Office Visits			
Primary Care Physician (PCP)	\$30 Co-pay per visit		Not Covered
Quality Blue Provider	\$15 Co-pay per visit		Not Covered
Specialist	\$45 Co-pay per visit		Not Covered
Affinity Health Group Copay	PCP: \$5 Co-pay per visit	Specialist: \$35 Co-pay per visit	Not Covered
Pregnancy Care	\$45 Co-pay		Not Covered
Mental & Nervous/Alcohol & Drug	\$30 Co-pay per visit		Not Covered
Urgent Care	\$45 Co-pay per visit		Not Covered
Lab & Low Tech Imaging	Fully Covered		Not Covered
High Tech Imaging (Free-standing)	Fully Covered		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)	\$500 Co-pay		Not Covered
Inpatient Professional Services	In Network Coinsurance		Not Covered
Outpatient Services			
Emergency Room (Waived if admitted)	\$350 Co-pay		
Outpatient Facility	\$500		Not Covered
Outpatient Professional	In Network Coinsurance		Not Covered
Physical, Speech & Occupational Therapy**	\$30 Co-pay per visit		Not Covered
Lab and Low & High Tech Imaging	Fully Covered		Not Covered
Other Covered Services			
Ground Ambulance (Medically necessary)	\$50 Co-pay		Not Covered
Prosthetics & Orthotics	DME Coinsurance		Not Covered
Skilled Nursing Facility*** (Co-pay plans: Co-pay per day, 3 day max)	\$500 Co-pay		Not Covered
Home Health Care Services***	In Network Coinsurance		Not Covered
Hospice Care Services***	In Network Coinsurance		Not Covered
Organ & Tissue Transplant****	\$500 Co-pay		Not Covered
Prescription Medication	Retail Copayment	Mail Copayment	
Drug Deductible	None		
Tier 1: Primarily generic drugs, although some brand-name drugs may fall into this category	\$15.00		\$45.00
Tier 2: Brand-Name Drugs	\$40.00		\$120.00
Tier 3: Primarily brand drugs that may have a therapeutic alternative that is in Tier 1 or Tier 2, although some generic drugs may fall into this category. Covered compounded drugs are included in this tier	\$70.00		\$210.00
Tier 4: Specialty Drugs (Limited to a 30 day supply per fill)	Plan: 90%; Member: 10% Specialty with \$150 max		

*When a brand drug is dispensed and a generic equivalent exists, members are required to pay the Tier 1 copay, plus the difference in cost between the brand drug dispensed and its generic equivalent.*

\*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.

\*\*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.

+Creditable prescription drug coverage means the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage. Non-creditable prescription drug coverage means the coverage is not expected to pay on average as much as standard Medicare prescription drug coverage. The coverage status determination shown above is subject to change based on the effective date and testing results for drug coverage as new parameters are released by CMS.

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.