



HMO Louisiana

Option 4- **Ochsner Only**
Network

Group Blue Connect POS

Blue Connect Copay 80/60 \$1,000C

Group Size: 51+

Effective 2025

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	\$1,000	\$2,000
Family Deductible	\$3,000	\$6,000
Individual Out of Pocket Max*	\$4,750	\$9,500
Family Out of Pocket Max*	\$9,500	\$19,000
Coinsurance	80%	60%
Durable Medical Equipment (DME) Coinsurance	80%	60%
Durable Medical Equipment (DME) Copay	N/A	N/A
Creditable Coverage+	Creditable	
Office Visits		
Primary Care Physician (PCP)	\$20 Co-pay per visit	Deductible then Coinsurance
Quality Blue Provider	\$20 Co-pay per visit	Deductible then Coinsurance
Specialist	\$55 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care	\$55 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	\$20 Co-pay per visit	Deductible then Coinsurance
Urgent Care	\$55 Co-pay per visit	Deductible then Coinsurance
Lab	Fully Covered	Deductible then Coinsurance
Low Tech Imaging	Fully Covered	Deductible then Coinsurance
High Tech Imaging (Free-standing)	Deductible then Coinsurance	Deductible then Coinsurance
Preventive and Wellness Office Visit	Fully Covered	Deductible then Coinsurance
Inpatient Services		
Inpatient Hospital Admission	Deductible then Coinsurance	Deductible then Coinsurance
Inpatient Professional Services	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Services		
Emergency Room (Waived if admitted)	\$350 Co-pay	
Outpatient Facility	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Professional	Deductible then Coinsurance	Deductible then Coinsurance
Physical, Speech, & Occupational Therapy**	\$40 Co-pay per visit	Deductible then Coinsurance
Lab	Fully Covered	Deductible then Coinsurance
Low Tech Imaging	Fully Covered	Deductible then Coinsurance
High Tech Imaging	Deductible then Coinsurance	Deductible then Coinsurance
Other Covered Services		
Ground Ambulance (Medically necessary)	\$50 Co-pay	Deductible then Coinsurance
Prosthetics & Orthotics	Deductible then DME Coinsurance	Deductible then Coinsurance
Skilled Nursing Facility***	Deductible then Coinsurance	Deductible then Coinsurance
Home Health Care Services***	Deductible then Coinsurance	Deductible then Coinsurance
Hospice Care Services***	Deductible then Coinsurance	Deductible then Coinsurance
Organ & Tissue Transplant****	Deductible then Coinsurance	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	