HMO Louisiana

Group Blue Connect POS

Blue Connect Copay 80/60 $1,000A

Effective 2025

Group Size: 51+

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	$7.00	$21.00
Tier 2: Brand-Name Drugs	$30.00	$90.00
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	

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HMO Louisiana

Effective 2025

HMOLA POS

Blue POS Copay 80/60 $750A

Group Size: 51+

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	$750	$1,500
Family Deductible	$2,250	$4,500
Individual Out of Pocket Max*	$4,000	$8,000
Family Out of Pocket Max*	$8,000	$16,000
Coinsurance	80%	60%
Durable Medical Equipment (DME) Coinsurance	80%	60%
Creditable Coverage+	Creditable	
Office Visits		
Primary Care Physician (PCP)	$30 Co-pay per visit	Deductible then Coinsurance
Quality Blue Provider	$15 Co-pay per visit	Deductible then Coinsurance
Specialist	$45 Co-pay per visit	Deductible then Coinsurance
Affinity Health Group Copay	PCP: $5 Co-pay per visit / Specialist: $35 Co-pay per visit	Deductible then Coinsurance
Pregnancy Care	$45 Co-pay	Deductible then Coinsurance
Mental & Nervous/Alcohol & Drug	$30 Co-pay per visit	Deductible then Coinsurance
Urgent Care	$45 Co-pay per visit	Deductible then Coinsurance
Lab & Low Tech Imaging	Fully Covered	Deductible then Coinsurance
High Tech Imaging (Free-standing)	Deductible then Coinsurance	Deductible then Coinsurance
Preventive & Wellness Office Visit	Fully Covered	Deductible then Coinsurance
Inpatient Services		
Inpatient Hospital Admission (Co-pay plans: Co-pay per day, 3 day max)	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**	$30 Co-pay per visit	Deductible then Coinsurance
Lab and Low & 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*** (Co-pay plans: Co-pay per day, 3 day max)	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	$7.00	$21.00
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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.

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