HMOLA HMO

HMO Copay 90 $500A Group Size: 51+ **Effective January 1, 2019**

HMO Louisiana

Your Covered Benefits Are:	Network	Non-Network
Individual Deductible	$500	None
Family Deductible	$1,500	None
Per Member Deductible within a Family	$500	None
Individual Out of Pocket Max*	$3,250	None
Family Out of Pocket Max*	$6,500	None
Per Member OOP Max within a Family*	$3,250	None
Coinsurance	90%	None
Durable Medical Equipment (DME) Coinsurance	80%	None
Office Visits		
Primary Care Physician (PCP)	$25 Co-pay per visit	Not Covered
Quality Blue Primary Care	$10 Co-pay per visit	Not Covered
Specialist	$40 Co-pay per visit	Not Covered
Pregnancy Care	$40 Co-pay	Not Covered
Mental & Nervous/Alcohol & Drug	$25 Co-pay per visit	Not Covered
Urgent Care	$40 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**	$25 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
Prescription Medication	**Retail Copayment**	**Mail Copayment**
Drug Deductible	None	
Tier 1: Value Drugs: Primarily Generic Drugs, some Brand-Name Drugs	$7.00	$21
Tier 2: Brand-Name Drugs	$30.00	$90
Tier 3: Primarily Brand-Name Drugs, some Generic Drugs, and Covered Compound Drugs	$70.00	$210
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.