

# Point of Service Plans

for Individuals



A subsidiary of Blue Cross and Blue Shield of Louisiana,  
independent licensees of the Blue Cross and Blue Shield Association.

[www.bcbsla.com](http://www.bcbsla.com)

## FROM A COMPANY YOU ALREADY KNOW AND TRUST...

A wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Inc. is part of the largest and most experienced health insurer in the state. We're proud to bring you Louisiana Blue Health Plans, our managed care programs with the strength and wisdom of a company doing business in Louisiana for more than 65 years.

### MANAGED CARE...WITH THE POWER OF BLUE!

Louisiana Blue Health Plans has a managed care plan to meet your health care needs and budget. Our Point of Service (POS) plan offers outstanding coverage at an affordable price. This plan features health care delivery from a primary care physician (PCP) who coordinates your health care needs within a strong network of physicians, hospitals and other providers with minimal out-of-pocket expense. POS plans are available in the Baton Rouge, New Orleans and Shreveport service areas.

### DIRECT-ACCESS NETWORK

Louisiana Blue Health Plans gives you the choices you deserve when it comes to your health. Our POS plan features "direct access" to network specialists without a referral from your PCP. A higher copayment applies to specialists. Refer to the Benefit Outline for details. POS plans are available in the Baton Rouge, New Orleans and Shreveport service areas.

### NON-NETWORK BENEFITS

In addition, our POS plan allows you to seek care outside of the network and still receive benefits. If you go to a doctor or hospital that isn't in the HMO Louisiana network, or if you receive care that is not authorized by the company, you must meet a deductible. Once the deductible is met, payments are shared between you and HMO Louisiana on a coinsurance basis.

### YOUR PRIMARY CARE PHYSICIAN

When enrolling, you choose a primary care physician (PCP) from the Louisiana Blue Health Plans provider directory. You can choose one PCP for the entire family or one for each family member. Your primary care physician:

- delivers and/or coordinates your health care needs
- files your PCP claims for you
- requires one simple copayment at the time of service
- can be a family practitioner, general practitioner, internist or pediatrician

*While OB/GYNs are not classified as PCPs under Louisiana Blue Health Plans, female members are entitled to two well-woman visits per benefit period to an OB/GYN within the HMO Louisiana network for routine gynecological exams.*

#### Changing Your Primary Care Physician

If you wish to change your primary care physician, simply call our Customer Service Department. One of our representatives will assist you with your changes and give you the effective date of your change.

### EASY COPAYMENTS

A copayment is a fixed-dollar amount that you pay when you receive services from your primary care physician, specialist or other network provider. You are responsible for a copayment each time a specified covered service is rendered. Choose the plan that fits your budget! See Benefit Outline for details.

### FREEDOM FROM PAPERWORK

Our subscribers also enjoy freedom from paperwork hassles. When you see a physician in the HMO Louisiana network, you pay one simple copayment and that's all — no claims filing, no deductibles and no waiting for reimbursement checks. The network physicians submit all claims and authorization requests and our Care Management Unit does the rest!

## DEPENDENT OUT-OF-AREA BENEFITS

For added convenience, our POS plan offers a benefit level for members with dependents — such as students — living outside of their designated service area. These dependents can apply to classify themselves as “out-of-area.” With this classification, some benefits and/or limits may vary, but these dependents still receive strong benefits on a deductible/coinsurance basis.

## WELLNESS AND PREVENTIVE CARE

Louisiana Blue Health Plans covers a full array of wellness and preventive services:

- one routine physical exam per benefit period
- one digital rectal exam and prostate (PSA) screening test per benefit period for members age 50 and older, or more frequently if recommended by physician
- one routine colon (hemoccult) test per benefit period
- two routine gynecological exams each benefit period
- one routine Pap smear per benefit period
- state-mandated immunizations, including those for dependent children under age 6 as required for school entry, and other immunizations as recommended by physician
- routine pediatric exams and immunizations for dependent children, other than those required for school entry
- one mammography exam per benefit period, or more frequently if recommended by physician

All services are subject to copayment or coinsurance where applicable. Routine vision exams also are included with all plans. Your copayment covers one routine vision exam every 24 months.

## PRESCRIPTION DRUG PROGRAM

Prescription drug benefits are included in all POS plans. Your retail copayments are based on a five-tier pricing structure, as follows:

| TIER: | DESCRIPTION:                                    | COPAYMENT: |
|-------|-------------------------------------------------|------------|
| 1     | generic drugs                                   | \$10       |
| 2     | brand-name drugs                                | \$20       |
| 3     | brand-name drugs with a therapeutic alternative | \$40       |
| 4     | multi-source brand drugs                        | \$55       |
| 5     | injectable drugs                                | \$50       |

A separate copayment is required for each prescription filled.

For maintenance drugs, our mail-order program dispenses a three-month supply for three copayments. This convenient program features free delivery of your medication usually within 10-14 days. *Certain drugs are excluded. Please see contract for details.*

### Prescription Drug Deductible Option

Louisiana Blue Health Plans offers a plan with a \$250 deductible for prescription drugs. Members must first meet this deductible before any prescription drug benefits are paid. Once the deductible is met, members pay the applicable retail copayment at the time of each prescription purchase.

## EMERGENCY CARE

As always, in limb- or life-threatening emergency situations, your first priority is to seek treatment at the nearest facility. In order for you to receive the highest level of benefits, we must authorize emergency inpatient admissions within 48 hours.

## URGENT CARE

Your POS plan also covers urgent care. Generally, an urgent situation is a medical condition that is not considered life threatening, but could result in serious injury or disability if you neglect to seek medical attention. You have the right to receive treatment for an urgent condition within 30 hours or less.

## YOUR ID CARD

You and each covered family member will receive a membership ID card in the mail. Your ID card includes the following:

- your name and member number
- prescription drug information
- your primary care physician's name and telephone number
- customer service and authorization telephone numbers
- *BlueCard*® Access Line
- copayment amounts

Please refer to

## BENEFITS THAT TRAVEL

If you need medical attention when you're traveling in another state, your benefits travel with you. As an HMO Louisiana member, you have access to health care benefits across the country and across the globe through the *BlueCard*® Program. The *BlueCard* gives you access to doctors and hospitals almost everywhere, giving you the peace of mind that you'll always find the care you need.

## AUTHORIZATION OF HOSPITAL ADMISSIONS

All elective and non-emergency hospital admissions require authorization before receiving treatment. Additionally, certain outpatient procedures require authorization before they are performed. You and your HMO Louisiana provider should obtain authorization prior to your hospital stay or outpatient procedure to ensure that you receive maximum benefits.

## GENERAL INFORMATION

**Services Not Covered, including, but not limited to:**

- charges exceeding the allowable charge
- cosmetic surgery
- treatment of eating disorders (unless otherwise required by law)
- treatment of mental disorders or alcohol and/or drug abuse
- contraceptive, fertility and impotence drugs
- sales tax or interest, except for prescription drugs that cost more than the prescription drug copayment
- services, treatments, procedures or equipment deemed medically unnecessary
- services covered by Workers' Compensation laws
- weight-reduction programs
- custodial care
- corrections for refractive errors of the eye
- pregnancy care and complications from pregnancy, except for ectopic pregnancies and miscarriages

Please see contract for complete list of limitations and exclusions.

### Pre-existing Condition Exclusion Period

There is a pre-existing condition exclusion period for the coverage of treatment for pre-existing conditions. That period is 365 days from the effective date of coverage. A pre-existing condition is a mental or physical condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the 365 days prior to the effective date of coverage or a condition for which medical advice, diagnosis, care, treatment or a prescribed drug was recommended or received during the 365-day period prior to the effective date of coverage. All pre-existing condition exclusion periods may be reduced for time served under a prior plan's health coverage as per state and federal guidelines.

### Termination

The contract may be terminated for nonpayment of premium, failure to meet eligibility requirements, fraud, residency/relocation outside of the HMO Louisiana service area, material misrepresentation or discontinuance of all or a particular type of coverage in the individual market.

POS refers to Louisiana Blue Health Plans Point of Service contract #13100 00284 0104R provided by HMO Louisiana, Inc., and is available only in the Baton Rouge, New Orleans and Shreveport service areas.

# POS BENEFIT OUTLINE

| Covered Benefits                                                                                                                                            | PLAN 1 Network                                                                                                                                                                                                                               | PLAN 2 Network                                                                                                                                                                                                                               | PLAN 3 Network                                                                                                                                                                                                                               | PLAN 4 Network                                                                                                                                                                                                                               | Non-Network (these benefits do not vary by plan)                                                                                                                                                                                                       | Dependent Out-of-Area (these benefits do not vary by plan)                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Benefit Period – Calendar Year<br>Lifetime Maximum – \$5,000,000                                                                                            |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                        |                                                                                                                                                                                                             |
| Benefit Period Deductible                                                                                                                                   | N/A                                                                                                                                                                                                                                          | N/A                                                                                                                                                                                                                                          | N/A                                                                                                                                                                                                                                          | N/A                                                                                                                                                                                                                                          | \$1,000<br>(\$3,000 family)                                                                                                                                                                                                                            | \$250<br>(\$750 family)                                                                                                                                                                                     |
| Out-of-Pocket Maximum                                                                                                                                       | \$1,000<br>(\$2,000 family)                                                                                                                                                                                                                  | \$1,000<br>(\$2,000 family)                                                                                                                                                                                                                  | \$1,000<br>(\$2,000 family)                                                                                                                                                                                                                  | \$1,000<br>(\$3,000 family)                                                                                                                                                                                                                  | \$2,500<br>(\$5,000 family)                                                                                                                                                                                                                            | \$1,000<br>(\$3,000 family)                                                                                                                                                                                 |
| Physician Office Visits<br>(including preventive & wellness services)                                                                                       | \$15 copayment for PCPs, chiropractors, speech, physical or occupational therapy, cardiac rehab or routine physical exams<br><br>\$30 copayment for specialists and allied health professionals (including other providers not listed above) | \$20 copayment for PCPs, chiropractors, speech, physical or occupational therapy, cardiac rehab or routine physical exams<br><br>\$35 copayment for specialists and allied health professionals (including other providers not listed above) | \$25 copayment for PCPs, chiropractors, speech, physical or occupational therapy, cardiac rehab or routine physical exams<br><br>\$40 copayment for specialists and allied health professionals (including other providers not listed above) | \$25 copayment for PCPs, chiropractors, speech, physical or occupational therapy, cardiac rehab or routine physical exams<br><br>\$40 copayment for specialists and allied health professionals (including other providers not listed above) | 60%/40% coinsurance for PCPs, chiropractors, speech, physical or occupational therapy, cardiac rehab or routine physical exams<br><br>60%/40% coinsurance for specialists and allied health professionals (including other providers not listed above) | 80%/20% coinsurance for PCPs, chiropractors, speech, physical or occupational therapy, cardiac rehab or routine physical exams<br><br>100% wellness (\$150 maximum per benefit period for routine physical) |
| Vision Care Exam<br>(one routine eye exam each 24-month period)                                                                                             | \$30 (per exam) any provider                                                                                                                                                                                                                 | \$35 (per exam) any provider                                                                                                                                                                                                                 | \$40 (per exam) any provider                                                                                                                                                                                                                 | \$40 (per exam) any provider                                                                                                                                                                                                                 | Same as Network Copayment                                                                                                                                                                                                                              | Same as Network Copayment                                                                                                                                                                                   |
| Prescription Drug/Retail<br>(Oral contraceptives excluded)(mail order: three copayments for a three-month supply)<br><br>See tier descriptions in brochure. | Tier 1: \$10<br>Tier 2: \$20<br>Tier 3: \$40<br>Tier 4: \$55<br>Tier 5: \$50                                                                                                                                                                 | Tier 1: \$10<br>Tier 2: \$20<br>Tier 3: \$40<br>Tier 4: \$55<br>Tier 5: \$50                                                                                                                                                                 | Tier 1: \$10<br>Tier 2: \$20<br>Tier 3: \$40<br>Tier 4: \$55<br>Tier 5: \$50                                                                                                                                                                 | (after \$250 deductible)<br>Tier 1: \$10<br>Tier 2: \$20<br>Tier 3: \$40<br>Tier 4: \$55<br>Tier 5: \$50                                                                                                                                     | Tier 1: \$10<br>Tier 2: \$20<br>Tier 3: \$40<br>Tier 4: \$55<br>Tier 5: \$50                                                                                                                                                                           | Tier 1: \$10<br>Tier 2: \$20<br>Tier 3: \$40<br>Tier 4: \$55<br>Tier 5: \$50                                                                                                                                |
| Emergency Room (one visit per day)                                                                                                                          | \$100 (waived if admitted)                                                                                                                                                                                                                   | \$100 (waived if admitted)                                                                                                                                                                                                                   | \$100 (waived if admitted)                                                                                                                                                                                                                   | \$100 (waived if admitted)                                                                                                                                                                                                                   | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Urgent Care (one visit per day)                                                                                                                             | \$50                                                                                                                                                                                                                                         | \$50                                                                                                                                                                                                                                         | \$50                                                                                                                                                                                                                                         | \$50                                                                                                                                                                                                                                         | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Inpatient Hospital Admission                                                                                                                                | \$200 (3 day max)                                                                                                                                                                                                                            | \$200 (3 day max)                                                                                                                                                                                                                            | \$250 (3 day max)                                                                                                                                                                                                                            | \$250 (3 day max)                                                                                                                                                                                                                            | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Inpatient Physician Services (surgical/medical)                                                                                                             | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Ambulatory Surgical Center (outpatient facility)                                                                                                            | \$200                                                                                                                                                                                                                                        | \$200                                                                                                                                                                                                                                        | \$250                                                                                                                                                                                                                                        | \$250                                                                                                                                                                                                                                        | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Physician Surgical Services (outpatient)                                                                                                                    | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Speech Therapy<br>(20 visits per benefit period maximum)(outpatient)                                                                                        | \$15 (per visit)                                                                                                                                                                                                                             | \$20 (per visit)                                                                                                                                                                                                                             | \$25 (per visit)                                                                                                                                                                                                                             | \$25 (per visit)                                                                                                                                                                                                                             | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Physical Therapy, Occupational Therapy & Cardiac Rehabilitation (outpatient)                                                                                | \$15 (per visit)                                                                                                                                                                                                                             | \$20 (per visit)                                                                                                                                                                                                                             | \$25 (per visit)                                                                                                                                                                                                                             | \$25 (per visit)                                                                                                                                                                                                                             | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Diagnostic X-Ray & Lab Testing                                                                                                                              | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | Plan pays 100%                                                                                                                                                                                                                               | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Ambulance                                                                                                                                                   | \$50 (per trip)                                                                                                                                                                                                                              | \$50 (per trip)                                                                                                                                                                                                                              | \$50 (per trip)                                                                                                                                                                                                                              | \$50 (per trip)                                                                                                                                                                                                                              | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Durable Medical Equipment, Prosthetics & Orthotics (up to \$25,000 per calendar year)                                                                       | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Skilled Nursing Facility<br>(90 days per benefit period)(must be pre-authorized)                                                                            | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Home Health Care Services<br>(60 days per benefit period)(must be pre-authorized)                                                                           | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Hospice Care Services<br>(180 days per benefit period)(must be pre-authorized)                                                                              | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 80%/20%                                                                                                                                                                                                                                      | 60%/40%                                                                                                                                                                                                                                                | 80%/20%                                                                                                                                                                                                     |
| Organ & Tissue Transplant<br>(must have written pre-authorization)                                                                                          | applicable inpatient & outpatient copayments                                                                                                                                                                                                 | applicable inpatient & outpatient copayments                                                                                                                                                                                                 | applicable inpatient & outpatient copayments                                                                                                                                                                                                 | applicable inpatient & outpatient copayments                                                                                                                                                                                                 | not covered                                                                                                                                                                                                                                            | 80%/20% (\$250,000 lifetime maximum)                                                                                                                                                                        |

This is an Informational brochure only and is not a contract nor intended to be construed as a contract. If there is any discrepancy between the language in this brochure and the language in the POS contract #13100 00284, the contract language will prevail.

**FOR INFORMATION ON INDIVIDUAL HEALTH PLANS CALL**

- Alexandria 318.442.8107
- Baton Rouge 225.295.2527
- Houma 985.853.5967
- Lafayette 337.593.5727
- Lake Charles 337.480.5315
- Monroe 318.398.4955
- New Orleans 504.832.5800
- Shreveport 318.795.4911



A subsidiary of Blue Cross and Blue Shield of Louisiana,  
independent licensees of the Blue Cross and Blue Shield Association.

The POS plan is available only in the Baton Rouge, New Orleans and Shreveport service areas. Premium will vary depending on plan and options selected. Rates are changed on the basis of age, area of residence and duration of coverage. Applications for coverage may be denied or coverage may be limited based on the health status of the applicant. The POS contract can be terminated for nonpayment of premium, failure to meet eligibility requirements, fraud, non-Louisiana residency, relocation outside of service area and material misrepresentation. Point of Services refers to contract number 13100 00284 0104R.

**Receipt  
POS Plans**

### Receipt

Receipt of \$\_\_\_\_\_ is hereby acknowledged for the initial premium and enrollment fee.

Make check payable to: HMO Louisiana, Inc. • P.O. Box 98029  
Baton Rouge, Louisiana 70898-9029

\_\_\_\_\_  
Subscriber's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Representative