

## Archdiocese of New Orleans

	NETWORK	DEPENDENT OUT-OF-AREA
<i>Calendar Year Deductible</i>	None	\$250 Individual / \$750 Family Aggregate
<i>Out-of-Pocket Calendar Year Maximum</i>	\$3,000 Individual / \$6,000 Family Aggregate	\$1,000 Individual / \$3,000 Family Aggregate (Excludes Deductible)
<b>OFFICE VISITS</b>		
<i>Office Visits</i>	\$30 Co-pay Per Visit	80 / 20 Coinsurance*
<i>Specialist Office Visits</i>	\$45 Co-pay Per Visit	80 / 20 Coinsurance*
<i>Vision Care</i>	\$45 Co-pay (1 Exam Every 24 Months)	\$45 Co-pay (1 Exam Every 24 Months)
<b>PREVENTIVE AND WELLNESS CARE (PPACA **Required Benefits)</b>		
<i>Office Visits</i>	No Co-pay, 100%	100% for Eligible Physical Exams
<i>Lab and X-ray</i>	No Co-pay, 100%	Deductible then Coinsurance
<b>OUTPATIENT SERVICES</b>		
<i>Rehabilitative Speech Therapy</i>	\$30 Co-pay	80 / 20 Coinsurance*
<i>Physical and Occupational Therapy</i>	\$30 Co-pay Per Visit	80 / 20 Coinsurance*
<i>X-ray &amp; Lab</i>	No Co-pay, 100%	80 / 20 Coinsurance*
<i>Surgery Facility Charge</i>	\$500 Co-pay Per Surgery*	80 / 20 Coinsurance*
<i>Professional Services</i>	No Co-pay, 90 / 10 Coinsurance*	80 / 20 Coinsurance*
<b>INPATIENT SERVICES</b>		
<i>Hospital</i>	\$500 Co-pay Per Day for 3 Days*	80 / 20 Coinsurance*
<i>Professional Services</i>	No Co-pay; 90 / 10 Coinsurance* **	80 / 20 Coinsurance*
<b>MENTAL HEALTH and SUBSTANCE ABUSE SERVICES</b>		
<i>Office Visit</i>	No Co-pay; 100%	
<i>Inpatient - Facility</i>	\$500 Co-pay Per Day for 3 Days*	80 / 20 Coinsurance*
<i>Inpatient – Professional Services</i>	No Co-pay; 100%	
<i>Outpatient Facility and Professional Services</i>	No Co-pay; 100%	
<b>BENEFITS THAT REQUIRE AUTHORIZATION (does not include list of outpatient services or drugs requiring authorization)</b>		
<i>Organ and Tissue Transplants</i>	Covered as any other illness	80 / 20 Coinsurance*
<i>Skilled Nursing Facility (90 day Max. Per Calendar Yr)</i>	No Co-pay, 90 / 10 Coinsurance*	80 / 20 Coinsurance*
<i>Home Health Care (60 Visit Max. Per Calendar Year)</i>	No Co-pay, 90 / 10 Coinsurance*	80 / 20 Coinsurance*
<i>Hospice (180 Day Max)</i>	No Co-pay, 90 / 10 Coinsurance*	80 / 20 Coinsurance*
<b>OTHER COVERED SERVICES</b>		
<i>Prescription Drug Copayments</i> <i>Refer to the contract for applicable supply limitations</i>	<b>Generic / Preferred Brand / Non-Preferred Brand / Multi-Source / Injectables</b> <b>-Contraceptives Excluded -</b>	
<i>Prescription Drug Deductible</i>	\$100 per calendar year with \$200 per family maximum. The deductible applies only to Brand products (Excludes generic) on both Retail and Mail Order benefits.	
<i>Retail – up to 30 day supply</i>	\$5 / \$30 / \$50 / \$60 / \$50	
<i>Mail Order – up to 90 day supply</i>	\$15 / \$90 / \$150 / \$180 / \$150	
	Lead with Generics Included	
<i>Prenatal Visits and Delivery</i>	\$45 Co-pay Per Pregnancy in addition to the Inpatient Hospital Co-pay for any related hospitalization	80 / 20 Coinsurance*
<i>Emergency Room</i>	\$100 Co-pay Per Visit; Waived if Admitted	\$100 Co-pay per Visit; Waived if Admitted
<i>Urgent Care Center</i>	\$50 Per Visit	80 / 20 Coinsurance*
<i>Ambulance</i>	\$50 Co-pay Per Trip	80 / 20 Coinsurance*
<i>Prosthetic Appliances</i>	No Co-pay; 80 / 20 Coinsurance*	80 / 20 Coinsurance*
<i>Durable Medical Equipment and Orthotics</i>	No Co-pay; 80 / 20 Coinsurance*	80 / 20 Coinsurance*

All benefits based on allowable charges.

\*Accrues to the Out of Pocket Maximum

\*\* Patient Protection and Affordable Care Act

NOTE: This is only an outline. All benefits are subject to the terms and conditions of the Benefit Plan. In the case of a discrepancy, the Benefit Plan will prevail. Exclusions and Limitations may apply.