2024- PGRMA 003ZABB

Acadia Parish Police Jury Managed Care Plan

Benefit Levels	*In Network Coverage Level*	*Out of Network Coverage Level*
Calendar Year Deductible	**No Deductible**	**$5000.00 Deductible**
Wellness/Preventive Care	**100% for all Preventative Services**	**In Network Only**
Adult Physical Examination	**100%**	**In Network Only**
Well Child Exams	**100%**	**In Network Only**
Routine GYN Exams	**100%**	**In Network Only**
Mammogram / Prostate Screening / Bone Density	**100%**	**In Network Only**
Routine Eye Exam (One per year)	**100%**	**In Network Only**
Immunizations, Including: Flu, Pneumonia, Shingles	**100%**	**In Network Only**
Routine Colonoscopy and EGD Testing	**100%**	**In Network Only**
Supplemental Accident Benefit - Treatment must be within 90 days following the accident.		
Charges must be reported as an accident on a claim form	**100% up to $300.00 then regular in network or out of network benefits apply.**	
Second Surgical Opinion (Required for certain procedures)	100% Coverage	
Smoking Cessation	**100%**	
Physician Services - General or Family Practice, Pediatrician, OB/GYN, Internal Medicine or Urgent Care Clinic		
Includes services rendered only by that doctor during that visit	**$30.00 co-pay per visit**	**Deductible then 50%**
Maternity - Physician Fees (dependent children not covered)	**$400.00 co-pay/Pregnancy**	**Deductible then 50%**
Urgent Care Center	**$30.00 co-pay per visit**	**$30.00 co-pay per visit**
Specialist Office Visit - Oncologist, Neurologist, Optometrist, Chiropractor, Dermatology, Cardiology etc.		
Includes services rendered only by that doctor during that visit	**$40.00 co-pay per visit**	**Deductible then 50%**
In office items without Office Visit		
In office injection w/out office visit billed	**$40.00 co-pay per visit**	**Deductible then 50%**
Minor in office surgery w/out office visit billed	**$40.00 co-pay per visit**	**Deductible then 50%**
Allergy testing w/out office visit billed	**80% coverage**	**Deductible then 50%**
Hearing/audiology testing in office w/out office visit billed	**80% coverage**	**Deductible then 50%**
Quest Select Benefit - Independent Network	**100% Coverage**	**In-Network Only**
Free Standing Lab / Radiology Clinic / Physician charges excluding office visit		
Baseline x-rays or labs other than Lab One	**$30.00 co-pay**	**Deductible then 50%**
MRI, Pet Scan, Sleep Study, Hida Scan	**$250.00 co-pay**	**Deductible then 50%**
Ct Scan	**$100.00 co-pay**	**Deductible then 50%**
Echo cardiogram, EKG, EMG, stress test, halter monitor, ultrasound, diagnostic mammogram at Imaging Center	**$30.00 co-pay**	**Deductible then 50%**
Lab / Radiology done at Facility (Hospital or Outpatient Surgery Center)		
Baseline x-ray or labs	**$30.00 co-pay**	**Deductible then 50%**
MRI, Pet Scan, Sleep Study, Hida Scan	**$250.00 co-pay**	**Deductible then 50%**
CT Scan	**$100.00 co-pay**	**Deductible then 50%**
Echo cardiogram, EKG, EMG, stress test, halter monitor, ultrasound, diagnostic mammogram	**$30.00 co-pay**	**Deductible then 50%**
Physical / Occupational / Speech Therapy		
PT clinic or home	**$40.00 co-pay/visit**	**Deductible then 50%**
Facility	**$40.00 co-pay/visit**	**Deductible then 50%**
Hospice	**100%**	**Deductible then 50%**
Home Health Care	**$40.00 co-pay/visit**	**Deductible then 50%**
Chemotherapy / Radiation / Dialysis	**$75.00 co-pay/visit**	**Deductible then 50%**
Cardiac Rehab	**$40.00 co-pay/visit**	**Deductible then 50%**
Durable Medical Equipment		
DME in office with office visit	**80%**	**Deductible then 50%**
DME from DME supplier	**80%**	**Deductible then 50%**

HOSPITAL SERVICES		
Emergency Room Services	$100.00 co-pay per visit	$100.00 co-pay per visit
Emergency Room Physician and All Related Charges	100%	100%
Out Patient Hospital /Ambulatory Surgery Center Procedures (other than diagnostic procedures listed above)	$275.00 co-pay per visit	Deductible then 50%
In Patient Hospital Admission	$350.00 co-pay/day, max of 5 days	Deductible + $500 co-pay, then 50% coverage
Maternity Inpatient Facility Fees	Same as any inpatient stay	Deductible + $500 co-pay, then 50% coverage
Hospital Related Charges: Physician, Radiology & Anesthesiology	100%	Deductible then 50%
Ambulance Services	Ground Transport $50 co-pay; Air Transport $250 co-pay	Ground Transport $50 co-pay; Air Transport $250 co-pay

Prescriptions (If drug costs less than co-pay amount, you pay the lesser amount)		
Deductible	$250.00 Deductible	In-Network Only
Pharmacy Dispensed		
Generic	$20.00 co-pay	In-Network Only
Preferred Brand Name	$35.00 co-pay	In-Network Only
Non-Preferred Brand Name	$70.00 co-pay	In-Network Only
- Mail Order	90 day supply for 2 co-pays	In-Network Only
Generic Mail Order	$40.00 co-pay	In-Network Only
Brand Mail Order	$70.00 co-pay	In-Network Only
Non-Preferred Brand Name	$140.00 co-pay	In-Network Only
Organ Transplant		
Recipient	$500.00 inpatient copay/day maximum 5 days	In-Network Only
Associated Costs	Subject to regular benefits	In-Network Only

Mental Health Care / Alcohol and Drug : Covered the same as any other illness		
Inpatient & Residential Treatment	$300.00 co-pay/day maximum of 5 days	Deductible then 50% coverage
Hospital related charges: physician, radiology	100%	Deductible then 50% coverage
Office Visit and Partial Hospitalization	$30.00 co-pay per visit	Deductible then 50% coverage

Please see attached for complete listing or contact CCMSI for further information

Required for surgical procedures or non-emergency hospital admission In-Network or Out-of-Network.
All Emergency admissions in and out of Network must be reported and approved within 48 hours of the admit.
Also, required for certain outpatient procedures including: MRI, Physical Therapy & Durable Medical Equipment
Chemotherapy/Radiation Treatment, Dialysis Treatmen, Out-patient Surgery.
Pre-certification is required at least 48 hours prior to any procedures.

Failure to pre-certify will result in the denial of the claim

Eligibility - All full time employees working 30 hours or more per week.

Elected officials and retirees may participate if designated an eligible class by the Group. Eligible dependents include legal spouses and dependent children up to the age of 26.

Non-Network Benefits :All out of network benefits are subject to review for resonable and customary fees. Any difference in the amount charged and the amount allowed will be the responsibility of the member. Eligible Expenses from a Non-Network provider are determined based on: Fees that are negotiated with the provider, a percentage of published rates that are allowed by Medicare for the same or similar service, 50% of the billed charge or a fee schedule that we develop.

PPO Network: Verity Health Network

WWW.VERITYHEALTH.COM

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