Louisiana

**OGB**
**MAGNOLIA LOCAL PLUS**

**COMPREHENSIVE HMO MEDICAL BENEFIT PLAN**
**SCHEDULE OF BENEFITS**

**Nationwide Network Coverage**
**Preferred Care Providers and BCBS National Providers**

**BENEFIT PLAN FORM NUMBER 40HR1607 R01/18**

| PLAN NAME | PLAN NUMBER |
|---|---|
| State of Louisiana Office of Group Benefits | ST222ERC |
| PLAN'S ORIGINAL BENEFIT PLAN DATE | PLAN'S ANNIVERSARY DATE |
| July 1, 2010 | January 1 |

| | |
|---|---|
| **Lifetime Maximum Benefit:** | **Unlimited** |
| **Benefit Period:** | 01/01/2018 – 12/31/2018 |
| **Deductible Amount Per Benefit Period:** | |
| **Individual:** | |
| Network Providers: | |
| Active Employees and Retirees on or after 3/1/15 (With and Without Medicare) | $400.00 |
| Retirees prior to 03/01/15 (With and Without Medicare) | $0 |
| Non-Network Providers: | No Coverage |
| **Individual + 1 Dependent:** | |
| Network Providers: | |
| Active Employees and Retirees on or after 3/1/15 (With and Without Medicare) | $800.00 |
| Retirees prior to 03/01/15 (With and Without Medicare) | $0 |
| Non-Network Providers: | No Coverage |

**Family (Individual + 2 or more Dependents):**

Network Providers:

| | |
|---|---|
| Active Employees and Retirees on or after 3/1/15 (With and Without Medicare) | $1,200.00 |
| Retirees prior to 03/01/15 (With and Without Medicare) | $0 |
| Non-Network Providers: | No Coverage |

**Out-of-Pocket Maximum per Benefit Period:**

| **Includes all eligible Medical and Pharmacy Copayments, Coinsurance Amounts, and Deductibles** | | | | |
|---|---|---|---|---|
| | Active Employees and Retirees on or after 3/1/2015 (With and Without Medicare) | | Retirees prior to 3/1/2015 (With and Without Medicare) | |
| | **Network** | **Non-Network** | **Network** | **Non-Network** |
| Individual | $3,500.00 | No Coverage | $2,000.00 | No Coverage |
| Individual + 1 Dependent | $6,000 | No Coverage | $3,000.00 | No Coverage |
| Family (Individual + 2 or more Dependents) | $8,500.00 | No Coverage | $4,000.00 | No Coverage |

**SPECIAL NOTES**

**Out-of-Pocket Maximum**

When the Out-of-Pocket Maximum, as shown above, has been satisfied, this Plan will pay 100% of the Allowable Charge toward eligible expenses for the remainder of the Plan Year.

**Eligible Expenses**

Eligible Expenses are reimbursed in accordance with a fee schedule of maximum Allowable Charges, not billed charges.

**All Eligible Expenses are determined in accordance with Plan Limitations and Exclusions.**

**Eligibility**

The Plan Administrator determines Eligibility for all Plan Participants.

**COPAYMENTS and COINSURANCE**

| | NETWORK PROVIDERS | | NON-NETWORK PROVIDERS |
|---|---|---|---|
| Physician Office Visits including surgery performed in an office setting:<br>• General Practice<br>• Family Practice<br>• Internal Medicine<br>• OB/GYN<br>• Pediatrics<br>• Geriatrics | $25.00<br>Copayment per Visit | | No Coverage |
| Allied Health/Other Professional Visits:<br>• Chiropractors<br>• Federally Funded Qualified Rural Health Clinic<br>• Nurse Practitioner<br>• Retail Health Clinic<br>• Physician Assistant | $25.00<br>Copayment per Visit | | No Coverage |
| Specialist Office Visits including surgery performed in an office setting:<br>• Physician<br>• Podiatrist<br>• Optometrist<br>• Midwife<br>• Audiologist<br>• Registered Dietician<br>• Sleep Disorder Clinic | $50.00<br>Copayment per Visit | | No Coverage |
| Ambulance Services – Ground | $50.00 Copayment | | $50.00 Copayment<br>(*Emergency Medical Transportation Only*) |
| Ambulance Services – Air<br>Non-emergency requires prior authorization[2] | $250.00 Copayment | | No Coverage |
| Ambulatory Surgical Center and Outpatient Surgical Facility | $100.00 Copayment | | No Coverage |
| Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan.*) | 100% - 0% | | No Coverage |
| Cardiac Rehabilitation<br>(Must begin within six (6) months of qualifying event; *Limited to 36 visits per Plan Year*) | $25.00/$50.00 Copayment per day depending on Provider[2,3]<br><br>$50.00 Copayment – Outpatient Facility[2,3] | | No Coverage |

[1]Subject to Plan Year Deductible, **if applicable**
[2]Pre-Authorization Required, **if applicable.**
**Not applicable for Medicare primary.**
[3]Age and/or Time Restrictions Apply

**COPAYMENTS and COINSURANCE**

| | NETWORK PROVIDERS | | NON-NETWORK PROVIDERS |
|---|---|---|---|
| Chemotherapy/Radiation Therapy | Office – $25.00 Copayment per Visit<br><br>Outpatient Facility 100% - 0%[1] | | No Coverage |
| Diabetes Treatment | 80% - 20%[1] | | No Coverage |
| Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities | $25.00 Copayment | | No Coverage |
| Dialysis | 100% - 0%[1] | | No Coverage |
| Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices | 80% - 20%[1,2] of first $5,000.00 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000.00 per Plan Year | | No Coverage |
| Emergency Room (*Facility Charge*) | $200.00 Copayment; Waived if Admitted | | |
| Emergency Medical Services (*Non-Facility Charges*) | 100% - 0%[1] | | 100% - 0%[1] |
| Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six (6) months following cataract surgery*) | Eyeglass Frames – Limited to a Maximum Benefit of $50.00[1,3] | | No Coverage |
| Flu shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*) | 100% - 0% | | 100% - 0% |
| Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*) | 80% - 20%[1,3] | | No Coverage |
| High-Tech Imaging – Outpatient<br>• CT Scans<br>• MRA/MRI<br>• Nuclear Cardiology<br>• PET Scans | $50.00 Copayment[2] | | No Coverage |
| Home Health Care (*limit of 60 Visits per Plan Year*) | 100% - 0%[1,2] | | No Coverage |
| Hospice Care (*limit of 180 Days per Plan Year*) | 100% - 0%[1,2] | | No Coverage |

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**COPAYMENTS and COINSURANCE**

| | NETWORK PROVIDERS | | NON-NETWORK PROVIDERS |
|---|---|---|---|
| Injections Received in a Physician's Office (*when no other health service is received*) | 100% - 0%[1] | | No Coverage |
| Inpatient Hospital Admission, All Inpatient Hospital Services Included | $100.00 Copayment per day[2], maximum of $300.00 per Admission | | No Coverage |
| Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable | 100% - 0%[1] | | No Coverage |
| Interpreter Expenses for the Deaf or Hard of Hearing | 100% - 0% | | No Coverage |
| Mastectomy Bras – Ortho-Mammary Surgical (*limited to three (3) per Plan Year*) | 80% - 20%[1] of first $5,000.00 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000.00 per Plan Year | | No Coverage |
| Mental Health/Substance Use Disorder – Inpatient Treatment and Intensive Outpatient Programs | $100.00 Copayment per day[2], maximum of $300.00 per Admission | | No Coverage |
| Mental Health/Substance Use Disorder – Office Visits and Outpatient Treatment (other than Intensive Outpatient Programs) | $25.00 Copayment per Visit | | No Coverage |
| Newborn – Sick, Services excluding Facility | 100% - 0%[1] | | No Coverage |
| Newborn – Sick, Facility | $100.00 Copayment per day[2], maximum of $300.00 per Admission | | No Coverage |
| Oral Surgery | 100% - 0%[1,2] | | No Coverage |
| Pregnancy Care – Physician Services | $90.00 Copayment per pregnancy | | No Coverage |
| Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.*) | 100% - 0%[3] | | No Coverage |

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**COPAYMENTS and COINSURANCE**

| | NETWORK PROVIDERS | | NON-NETWORK PROVIDERS |
|---|---|---|---|
| Rehabilitation Services – Outpatient:<br>• Speech<br>• Physical/Occupational *(Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.)*<br><br>*(Visit limits are combination of Network and Non-Network Benefits; Visit limits do not apply when services are provided for Autism Spectrum Disorders)* | $25.00 Copayment per Visit | | No Coverage |
| Skilled Nursing Facility – Network (*limit of 90 days per Plan Year*) | $100.00 Copayment per day[2], maximum of $300.00 per Admission | | No Coverage |
| Sonograms and Ultrasounds (*Outpatient*) | $50.00 Copayment | | No Coverage |
| Urgent Care Center | $50.00 Copayment | | No Coverage |
| Vision Care (Non-Routine) Exam | $25.00/$50.00 Copayment depending on Provider | | No Coverage |
| X-ray and Laboratory Services (*low-tech imaging*) | Office or Independent Lab 100% - 0%<br>Hospital Facility 100% - 0%[1] | | No Coverage |

[1]Subject to Plan Year Deductible, **if applicable**
[2]Pre-Authorization Required, **if applicable.**
**Not applicable for Medicare primary.**
[3]Age and/or Time Restrictions Apply

## ORGAN AND BONE MARROW TRANSPLANTS

**Authorization is Required Prior to Services Being Performed**

Organ and Bone Marrow Transplants and evaluation for a Plan Participant's suitability for Organ and Bone Marrow transplants will not be covered unless a Plan Participant obtains written authorization from the Claims Administrator, prior to services being rendered.

Network Benefits: ..... 100% - 0% after deductible
Non-Network Benefits: ..... Not Covered

## CARE MANAGEMENT

Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, Benefits will be denied.

### Authorization of Inpatient and Emergency Admissions

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information.

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with the other Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

The following Admissions require Authorization prior to the services being rendered.

• Inpatient Hospital Admissions (Except routine maternity stays)
• Inpatient Mental Health and Substance Use Disorder Admissions
• Inpatient Organ, Tissue and Bone Marrow Transplant Services
• Inpatient Skilled Nursing Facility Services

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands with a BlueCard Worldwide provider are covered at the Network Benefit level. NO BENEFITS are payable for non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands from a non-BlueCard Worldwide Provider

### Authorization of Outpatient Services, Including Other Services and Supplies:

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable unless the procedure is deemed Medically Necessary. If the procedure is deemed Medically Necessary, the Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage. If the procedure is not deemed Medically Necessary, the Plan Participant is responsible for all charges incurred.

The following list of Outpatient services and supplies require Authorization prior to the services being rendered or supplies being received.

- Air Ambulance – Non Emergency
- Applied Behavior Analysis
- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Day Rehabilitation Programs
- Durable Medical Equipment (Greater than $300.00)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump

- Infusion Therapy (Exception: Infusion Therapy performed in a Physician's office does not require prior Authorization. The Drug to be infused may require prior Authorization).
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery
- Organ Transplant Evaluation
- Orthotic Devices (Greater than $300.00)
- Outpatient pain rehabilitation or pain control programs
- Partial Hospitalization Programs
- PET Scans
- Physical/Occupational Therapy (Greater than 50 visits)
- Prosthetic Appliances (Greater than $300.00)
- Residential Treatment Centers
- Sleep Studies (except those performed in the home)
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Vacuum Assisted Wound Closure Therapy

**Population Health – In Health: Blue Health**

The Population Health program targets populations with one or more chronic health conditions. The current chronic health conditions identified by OGB are diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). OGB may supplement or amend the list of chronic health conditions covered under this program at any time. (The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.)

Through the In Health: Blue Health Services program, OGB offers an incentive to Plan Participants on Prescription Drugs used to treat the chronic conditions listed above.

a. OGB Plan Participants participating in the program qualify for $0 Copayment for certain Generic Prescription Drugs approved by the U. S. Food and Drug Administration (FDA) for any of the listed chronic health conditions.

b. OGB Plan Participants participating in the program qualify for $20.00 Copayment (31 day supply), $40.00 Copayment (62 day supply) or $50.00 Copayment (93 day supply) for certain Preferred Brand-Name Prescription Drugs for which an FDA-approved Generic version is not available.

c. OGB Plan Participants participating in the program qualify for $40.00 Copayment (31 day supply), $80.00 Copayment (62 day supply) or $100.00 Copayment (93 day supply) for certain Non-Preferred Brand-Name Prescription Drug. Non-Preferred drugs typically have lower cost alternatives available in the same drug class.

If an OGB Plan Participant chooses a Brand-Name Drug for which an FDA-approved Generic version is available, the OGB Plan Participant pays the difference between the Brand-Name and Generic cost, plus a $40.00 Copayment for a 31 day supply.

The In Health: Blue Health Services prescription incentive does not apply to any Prescription Drugs not used to treat one of the listed health conditions with which you have been diagnosed. Please refer to the Care Management article, Population Health – In Health: Blue Health section of the Benefit Plan for complete information on how to qualify for this incentive.

## PRESCRIPTION DRUGS

Prescription Drug Benefits are provided under the Hospital Benefits and Medical and Surgical Benefits Articles of the Plan, and under the pharmacy benefit program provided by OGB's Pharmacy Benefits Manager (sometimes "PBM").

### Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana provides Claims Administration services **only** for Prescription Drugs dispensed as follows:

Prescription Drugs Covered Under Hospital Benefits and Medical and Surgical Benefits

1. Prescription Drugs dispensed during an Inpatient or Outpatient Hospital stay, or in an Ambulatory Surgical Center are payable under the Hospital Benefits.

2. Medically necessary/non-investigational Prescription Drugs requiring parenteral administration in a Physician's Office are payable under the Medical and Surgical Benefits.

3. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician's office are payable under the Medical and Surgical Benefits.

   All other eligible pharmacy benefits will be provided by OGB'S Pharmacy Benefit Manager.

### Authorizations

The following categories of Prescription Drugs require Prior Authorization. The Plan Participant's Physician must call 1-800-842-2015 to obtain the Authorization. The Plan Participant or his Physician should call the Customer Service number on the Plan Participant's ID card, or check the Claims Administrator's website at **www.bcbsla.com/ogb** for the most current list of Prescription Drugs that require Prior Authorization:

- Growth hormones*
- Anti-tumor necrosis factor drugs**
- Intravenous immune globulins*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*

* Shall include all drugs that are in this category.

**Therapeutic/Treatment Vaccines** – Examples include, but are not limited to vaccines to treat the following conditions:

- Allergic Rhinitis
- Alzheimer's Disease
- Cancers
- Multiple Sclerosis

**Therapeutic/Treatment Vaccines:**

Network Providers: ..... 100% - 0%
Non-Network Providers: .....Not Covered

**OGB'S Pharmacy Benefit Manager**

**MedImpact Formulary: 3-Tier Plan Design***

OGB's Pharmacy Benefit Manager for the 2018 Plan year is MedImpact. OGB will use the MedImpact Formulary to help Plan Participants select the most appropriate, lowest-cost options. The Formulary is reviewed on at least a quarterly basis to re-assess drug tiers based on the current prescription drug market. Plan Participants will continue to pay a portion of the cost of their prescriptions in the form of a co-pay or co-insurance. The amount Plan Participants pay toward their prescription depends on whether they receive a generic, preferred brand or non-preferred brand name drug. You must use drugs on the Formulary to qualify for pharmacy benefits under the Plan.

*These changes do not affect Plan Participants with Medicare as their primary coverage.

| PRESCRIPTION DRUG | PLAN PARTICIPANT PAYS |
|---|---|
| Generic | 50% up to $30.00 |
| Preferred | 50% up to $55.00 |
| Non-Preferred | 65% up to $80.00 |
| Specialty | 50% up to $80.00 |
| The pharmacy out-of-pocket threshold is $1,500.00. Once met: | |
| Generic | $0 co-pay |
| Preferred | $20.00 co-pay |
| Non-Preferred | $40.00 co-pay |
| Specialty | $40.00 co-pay |

There may be more than one drug available to treat your condition. We encourage you to speak with your Physician regularly about which drugs meet your needs at the lowest cost to you.

For more information on the pharmacy benefit, visit the website at **https://mp.medimpact.com/ogb** or **www.groupbenefits.org** or call MedImpact member services at 1-800-910-1831.