

OGB Medical Benefits Comparison for Active Employees and Non-Medicare Retirees

Effective January 1, 2014

COVERED BENEFIT: NETWORK	PPO Plan (nationwide) <i>Administered by Blue Cross and Blue Shield of La.</i>	HMO Plan (nationwide) <i>Administered by Blue Cross and Blue Shield of La.</i>	CDHP-HSA (nationwide)** <i>Administered by Blue Cross and Blue Shield of La.</i>	Medical Home HMO Plan (Regions 1,5,6,7,8,9)^{7, 10} <i>Insured by Vantage Health Plan</i>
Lifetime Maximum Benefit (all eligible expenses) Plan Year Deductible - Employees and Dependents	Unlimited \$500 active; \$300 retired Family unit maximum: 3 individual deductibles	Unlimited In-network: None Out-of-network: Separate \$1,000 deductible per person; Separate \$3,000 deductible per family	Unlimited Must meet deductible before co-insurance applies » Employee - \$1,250 » Employee plus one (spouse or child) - \$2,500 * » Family - \$3,000 *	Unlimited None
Maximum In-Network Out-Pocket Expense <i>Includes all eligible co-insurance, co-payments and deductibles</i>	<i>See the table on the back of this sheet</i>	\$1,000 per person (\$4,000 non-network) \$3,000 per family (\$12,000 non-network)	<i>See the table on the back of this sheet (includes prescription drug co-payments)</i>	» \$1,000 per person » \$3,000 per family
Hospital Services - Inpatient Surgeon, Anesthesia, Lab, X-rays & Injections Hospital Emergency Room <i>(Facility only - Authorization required after admission)</i>	Member pays 10% of contracted rate ^{1,2} Member pays 10% of contracted rate ¹ \$150 separate deductible; waived if admitted Member pays 10% of contracted rate ¹	\$100 per day ² ; \$300 maximum per admission \$0 co-payment \$100 co-payment; waived if admitted	Member pays 20% of contracted rate ^{1,2} Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ¹	\$200 per day ² ; \$600 maximum per admission \$0 co-pay ⁵ \$150 co-payment; waived if admitted
Ambulatory Surgical Facilities Physician Visits Pregnancy Care (physician only) MRI/CAT Scan Sonograms - Outpatient Chemotherapy/Radiation Therapy Pre-Admission Testing Dialysis Cardiac Rehabilitation Therapy <i>(must begin within 6 months of qualifying event)</i>	Member pays 10% of contracted rate ¹ Member pays 10% of contracted rate ¹ Member pays 10% of contracted rate ¹ Member pays 10% of contracted rate ¹ Member pays 10% of contracted rate ¹ Member pays 10% of contracted rate ¹ Member pays 10% of contracted rate ¹ Member pays 10% of contracted rate ¹ Member pays 10% of contracted rate ^{1,3}	\$100 co-payment \$15 PCP/\$25 specialist (no referral required) \$90 co-payment \$50 co-payment ² \$25 co-payment \$15 co-payment office visit; \$0 co-pay outpatient facility \$0 co-payment \$0 co-payment \$15/\$25 co-pay office visit; \$25 co-pay outpatient facility ³	Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ¹ Member pays 20% of contracted rate ^{1,3}	\$200 co-payment ² \$5 PCP/\$45 specialist (no referral required) \$5 co-pay for initial visit only (no auth required) \$150 co-payment per test ² \$150 co-payment per test ² (except maternity) Member pays 20% ² Member pays 0% 20% co-insurance ² \$45 co-payment per visit ²
Physical and Occupational Therapy	Member pays 10% of contracted rate ^{1,3,6,8}	\$15 co-payment	Member pays 20% of contracted rate, visit limits apply, see plan document ^{1,6,8}	20% co-insurance ^{2,6}
Speech Therapy Oral Surgery (refer to plan document) Routine Pap Test Routine Mammogram Routine PSA Screening Durable Medical Equipment	Member pays 10% of contracted rate ^{1,2,3,6,8} Member pays 0% of contracted rate Member pays 0% of contracted rate ³ Member pays 0% of contracted rate ³ Member pays 0% of contracted rate ³ Member pays 10% of contracted rate ¹	\$15 co-payment ² \$25 co-payment \$0 co-payment ³ \$0 co-payment ³ \$0 co-payment ³ Member pays 20% of contracted rate up to \$5,000, then payable at 100% ²	Member pays 20% of contracted rate ^{1,6,8} Member pays 20% of contracted rate ¹ Member pays 0%, deductible does not apply ³ Member pays 0%, deductible does not apply ³ Member pays 0%, deductible does not apply ³ Member pays 20% of contracted rate ^{1,2}	20% co-insurance ^{2,6} \$45 specialist co-pay or \$200 surgery co-pay ² Member pays 0% ³ Member pays 0% ³ Member pays 0% ³ 20% co-insurance ²
Home Health Care	Member pays 10% of negotiated rate ¹	\$0 co-payment Limited to 150 visits per plan year ²	Member pays 20% of contracted rate ^{1,2} Limited to 60 visits per plan year	20% co-insurance ²
Hospice Care Preventive Care (Wellness) Annual Eye Exam Prescription Drug Benefit In-Network (retail)	Member pays 20% of negotiated rate ¹ Member pays 0% of contracted rate ³ Not covered Member pays 50%; max \$50 per 31-day fill; after \$1,200 per person per plan year, co-pay \$15 brand, \$0 generic NOTE: Member who chooses brand-name drug for which approved generic version is available pays cost difference between brand-name drug & generic drug, plus 50 percent co-pay for brand-name drug; cost difference does not apply to \$1,200 out-of-pocket max. (Administered by MedImpact)	\$0 co-payment ² \$0 co-payment \$15/\$25 co-payment ³ Member pays 50%; max \$50 per 31-day fill; after \$1,200 per person per plan year, co-pay \$15 brand, \$0 generic NOTE: Member who chooses brand-name drug for which approved generic version is available pays cost difference between brand-name drug & generic drug, plus 50 percent co-pay for brand-name drug; cost difference does not apply to \$1,200 out-of-pocket max. (Administered by MedImpact)	Member pays 20% of contracted rate; 360 day limit ^{1,2} Member pays 0%, deductible does not apply ³ Not covered Subject to deductible; co-payments: » \$10 co-payment - Generic » \$25 co-payment - Preferred Brand » \$50 co-payment - Non-preferred Brand » \$50 co-payment - Specialty • 31-day supply for one copayment • 62-day supply for two copayments • 93-day supply for three copayments » Maintenance drugs: not subject to deductible; subject to applicable co-payments above <i>(Administered by Express Scripts)</i>	20% co-insurance ² \$0 co-payment \$45 specialist office visit co-payment ³ » Low-cost generic: \$3 co-payment per 30-day fill » Non-preferred generics: \$10 per 30-day fill » Preferred brand: \$45 co-payment per 30-day fill » Non-preferred brand: \$95 co-payment per 30-day fill » Specialty drugs: 33% co-insurance per 30-day fill <i>(Administered by Catamaran)</i>
Mail Order Prescription Drug Program	Same as above	Same as above	Same as above	» 30-day supply for one co-payment » 60-day supply for two co-payments » 90-day supply for three co-payments » Not available for specialty drugs <i>(Administered by Catamaran)</i>
Mental Health/Substance Abuse Treatment - Inpatient Mental Health/Substance Abuse Treatment - Outpatient	Member pays 10% of contracted rate ^{1,2} <i>(Administered by Blue Cross and Blue Shield of La.)</i> Member pays 10% of contracted rate ¹ <i>(Administered by Blue Cross and Blue Shield of La.)</i>	\$100 co-payment per day; \$300 max per admit ² <i>(Administered by Blue Cross and Blue Shield of La.)</i> \$15 office visit co-payment <i>(Administered by Blue Cross and Blue Shield of La.)</i>	Member pays 20% of contracted rate ^{1,2} <i>(Administered by Blue Cross and Blue Shield of La.)</i> Member pays 20% of contracted rate ¹ <i>(Administered by Blue Cross and Blue Shield of La.)</i>	\$200 co-payment per day; \$600 maximum admission ² <i>(Administered by Vantage Health Plan)</i> \$45 co-payment per visit <i>(Administered by Vantage Health Plan)</i>
COVERED BENEFIT: NON-NETWORK	» All above-listed services are paid by the member at 30% of fee schedule except for emergency room and services, oral surgery, inpatient treatment and prescription drugs ^{1,4,9} » Inpatient requires a \$50 copayment for up to 5 days	» All above-listed services are paid by the member at 30% of fee schedule except for emergency room and emergency medical services and prescription drugs ^{1,4,9}	» All above-listed services are paid by the member at 30% of fee schedule except for emergency room and services, oral surgery, preventive care and prescription drugs ^{1,4,9}	Worldwide emergency and urgent care covered at Tier 1 in-network benefit level; all other services require prior plan approval; separate deductible of \$1000 member/\$3000 family and 50% co-insurance applies ^{1,2,4}

This comparison chart is a summary of plan features. For full details of the plan, refer to the official plan document.

¹ Subject to plan year deductible and/or co-insurance

² Pre-authorization required

³ Age and/or time restrictions apply

⁴ Member pays difference between billed amount and fee schedule

⁵ Not applicable to out-of-network hospital-based providers at in-network facilities. Provider can balance bill patient

⁶ Speech therapy maximum of 26 visits per year. Occupational and Physical Therapy combined for maximum 50 visits per plan year

⁷ Tier I and Tier II networks available. All medical benefits shown are for the Tier I network. Tier II network benefits require an additional 20% coinsurance.

⁸ Visit limits do not apply when services are provided for autism spectrum disorders.

⁹ See plan document for details.

¹⁰ The benefits outlined in this column were provided by Vantage Health Plan. OGB is not responsible for the accuracy of this information.

¹ Subject to plan year deductible and/or co-insurance

² Pre-authorization required

³ Age and/or time restrictions apply

⁴ Member pays difference between billed amount and fee schedule

⁵ Not applicable to out-of-network hospital-based providers at in-network facilities. Provider can balance bill patient

Health Savings Account (HSA): State contributes \$200 to each plan member's qualified HSA & matches up to \$575 per plan year in additional contributions. Refer to plan document for details.

* Employee-plus-one unit or family unit must satisfy total deductible before co-insurance applies (prescription drugs included)

** Only active employees are eligible to enroll

Maximum Out-of-Pocket Details

PPO

Includes all eligible Copayments, Coinsurance Amounts and Deductibles				
	Active Employees		Retirees without Medicare	
	Network	Non-Network	Network	Non-Network
Employee Only	\$1,500	\$3,500	\$1,300	\$3,300
Employee Plus One (Spouse or Child)	\$3,000	\$7,000	\$2,600	\$6,600
Family of 3	\$4,500	\$10,500	\$3,900	\$9,900
Family of 4	\$5,500	\$12,700	\$4,900	\$12,700
Family of 5	\$6,500	\$12,700	\$5,900	\$12,700
Family of 6	\$7,500	\$12,700	\$6,900	\$12,700
Family of 7	\$8,500	\$12,700	\$7,900	\$12,700
Family of 8	\$9,500	\$12,700	\$8,900	\$12,700
Family of 9	\$10,500	\$12,700	\$9,900	\$12,700
Family of 10	\$11,500	\$12,700	\$10,900	\$12,700
Family of 11	\$12,500	\$12,700	\$11,900	\$12,700
Family of 12 or More	\$12,700	\$12,700	\$12,700	\$12,700

Special Notes:

Out-of-pocket amounts for care received from Network and Non-Network Providers accrue to the Out-of-Pocket maximum.

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

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges; not billed charges.

CDHP

Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Co-Payments		
	Active Employees	
	Network	Non-Network
Employee Only	\$3,250	\$3,250
Employee Plus One (Spouse or Child)	\$6,500	\$6,500
Family of 3	\$9,000	\$9,000
Family of 4	\$11,000	\$11,000
Family of 5 or more	\$11,900	\$11,900

Special Notes:

Out-of-Pocket amounts for services received from a Network Provider that accrue to the Out-of-Pocket Amount for Network Providers **will not** count toward the Out-of-Pocket Amount for Non-Network Providers.

Out-of-Pocket amounts for services received from a Non-Network Provider that accrue to the Out-of-Pocket Amount for Non-Network Providers **will not** count toward the Out-of-Pocket Amount for Network Providers.

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges; not billed charges.

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OFFICE OF GROUP BENEFITS OFFICIAL SCHEDULE OF PREMIUM RATES

Effective January 1, 2014

	PPO <i>Administered by Blue Cross</i>			HMO <i>Administered by Blue Cross</i>			CDHP with HSA <i>Administered by Blue Cross</i>			Medical Home HMO <i>Regions 1, 5, 6, 7, 8 & 9 Insured by Vantage Health Plan</i>		
	State Share	Employee Share	Total	State Share	Employee Share	Total	State Share	Employee Share	Total	State Share	Employee Share	Total
ACTIVE EMPLOYEE												
SINGLE	424.30	141.42	565.72	400.86	133.62	534.48	329.38	109.78	439.16	424.30	148.46	572.76
WITH SPOUSE	742.26	459.38	1201.64	701.18	433.94	1135.12	576.18	356.58	932.76	742.26	457.46	1199.72
WITH CHILDREN	486.42	203.54	689.96	459.52	192.28	651.80	377.70	158.10	535.80	486.42	209.06	695.48
FAMILY	775.10	492.22	1267.32	732.18	464.94	1197.12	601.64	382.04	983.68	775.10	489.30	1264.40
RETIREE WITHOUT MEDICARE & RE-EMPLOYED RETIREE												
SINGLE	911.10	141.42	1052.52	863.90	133.62	997.52	N/A	N/A	N/A	903.98	148.46	1052.44
WITH SPOUSE	1399.18	459.38	1858.56	1327.38	433.94	1761.32	N/A	N/A	N/A	1389.78	457.46	1847.24
WITH CHILDREN	968.82	203.54	1172.36	918.88	192.28	1111.16	N/A	N/A	N/A	961.64	209.06	1170.70
FAMILY	1387.14	462.38	1849.52	1314.66	438.22	1752.88	N/A	N/A	N/A	1378.74	459.58	1838.32
RETIREE WITH 1 MEDICARE												
SINGLE	256.72	85.56	342.28	247.50	82.50	330.00	N/A	N/A	N/A	256.72	95.72	352.44
WITH SPOUSE	948.46	316.14	1264.60	904.56	301.52	1206.08	N/A	N/A	N/A	946.20	315.40	1261.60
WITH CHILDREN	444.30	148.10	592.40	425.76	141.92	567.68	N/A	N/A	N/A	444.30	154.66	598.96
FAMILY	1263.72	421.24	1684.96	1204.02	401.34	1605.36	N/A	N/A	N/A	1257.02	419.02	1676.04
RETIREE WITH 2 MEDICARE												
WITH SPOUSE	461.44	153.80	615.24	443.68	147.88	591.56	N/A	N/A	N/A	461.44	159.86	621.30
FAMILY	571.32	190.44	761.76	549.30	183.10	732.40	N/A	N/A	N/A	571.32	194.44	765.76
C.O.B.R.A.												
SINGLE	0.00	577.02	577.02	0.00	545.16	545.16	0.00	447.94	447.94	0.00	584.22	584.22
WITH SPOUSE	0.00	1225.66	1225.66	0.00	1157.82	1157.82	0.00	951.42	951.42	0.00	1223.70	1223.70
WITH CHILDREN	0.00	703.76	703.76	0.00	664.84	664.84	0.00	546.52	546.52	0.00	709.38	709.38
FAMILY	0.00	1292.66	1292.66	0.00	1221.06	1221.06	0.00	1003.34	1003.34	0.00	1289.68	1289.68
DISABILITY C.O.B.R.A.												
SINGLE	0.00	848.58	848.58	0.00	801.72	801.72	0.00	658.74	658.74	0.00	859.14	859.14
WITH SPOUSE	0.00	1802.46	1802.46	0.00	1702.68	1702.68	0.00	1399.14	1399.14	0.00	1799.58	1799.58
WITH CHILDREN	0.00	1034.94	1034.94	0.00	977.70	977.70	0.00	803.70	803.70	0.00	1043.22	1043.22
FAMILY	0.00	1900.98	1900.98	0.00	1795.68	1795.68	0.00	1475.52	1475.52	0.00	1896.60	1896.60

NOTE: 1) The breakdown between State Share and Employee Share may not be accurate for certain school board employees due to local funding that affects agency contributions. Total premium columns are correct for all agencies.
2) All plan members who retired on or after July 1, 1997, must have Medicare Parts A and B to qualify for reduced premium rates.

Approved By: 08/28/2013