Louisiana

OGB
MAGNOLIA LOCAL PLUS PLAN B

COMPREHENSIVE HMO MEDICAL BENEFIT PLAN
SCHEDULE OF BENEFITS

Individual, Plus One Dependent (Medicare Paying Primary for Two): Retirees prior to March 1, 2015
Individual, Plus Two or More Dependents (Medicare Paying Primary for Three): Retirees prior to March 1, 2015

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

BENEFIT PLAN FORM NUMBER 40HR1607 R01/25

PLAN NAME
State of Louisiana Office of Group Benefits

PLAN NUMBER
ST222ERC

PLAN'S ORIGINAL BENEFIT PLAN DATE
July 1, 2010

PLAN'S ANNIVERSARY DATE
January 1st

Lifetime Maximum Benefit: **Unlimited**

Benefit Period: .....01/01/2025 – 12/31/2025

DEDUCTIBLE AMOUNT PER BENEFIT PERIOD:

	Retirees prior to 3/1/2015	
	Network Providers	**Non-Network Providers**
Individual + 1 Dependent	$0.00	No Coverage
Individual + 2 or More Dependents	$0.00	No Coverage

OUT-OF-POCKET MAXIMUM PER BENEFIT PERIOD:

WHEN MEDICARE IS THE PRIMARY PAYER FOR AT LEAST ONE PLAN PARTICIPANT

Includes all eligible Copayments, Coinsurance Amounts and Deductibles		
	Retirees prior to 3/1/2015	
	Network Providers	**Non-Network Providers**
Individual + 1 Dependent (Medicare Paying Primary for Two)	Medical: $0.00 Prescription: $1,500.00	No Coverage
Individual + 2 or More Dependents (Medicare Paying Primary for Three)	Medical: $0.00 Prescription: $1,500.00	No Coverage
Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.		

SPECIAL NOTES

Out-of-Pocket Amounts

When the Out-of-Pocket Amount, 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: • General Practice • Family Practice • Internal Medicine • Midwife • OB/GYN • Pediatrics • Geriatrics	$0.00 Copayment per Visit		No Coverage
Allied Health/Other Professional Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinic • Nurse Practitioner • Retail Health Clinic • Physician Assistant	$0.00 Copayment per Visit		No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Audiologist • Registered Dietitian • Sleep Disorder Clinic	$0.00 Copayment per Visit		No Coverage
Ambulance Services – Ground			
Emergency Ground Ambulance Services In-State	$0.00 Copayment		$0.00 Copayment
Emergency Ground Ambulance Services Out-of-State	$0.00 Copayment		$0.00 Copayment
Non-Emergency Ground Ambulance Services	$0.00 Copayment		No Coverage
Ambulance Services – Air Non-emergency requires Prior Authorization[2]	$0.00 Copayment		$0.00 Copayment (*Emergency Medical Transportation Only*).
Ambulatory Surgical Center and Outpatient Surgical Facility	$0.00 Copayment		No Coverage
Bariatric Surgery Services: • Facility Services	$2,500.00 Copayment[2,3]		No Coverage
• Professional Services	90% -10%[2,3]		No Coverage
• Preoperative and Postoperative Medical Services	80% - 20%[2,3]		No Coverage

NOTE: No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan

[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.

	NETWORK PROVIDERS		NON-NETWORK PROVIDERS
Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan*).	100% - 0%		No Coverage
Cardiac Rehabilitation (Must begin within six (6) months of qualifying event; *Limited to 36 visits per Plan Year*).	$0.00/$0.00 Copayment per day depending on Provider[2,3] $0.00 Copayment – Outpatient Facility[2,3]		No Coverage
Chemotherapy/Radiation Therapy	Office – $0.00 Copayment per Visit Outpatient Facility 100% - 0%[1]		No Coverage
Diabetes Treatment	100% - 0%[1]		No Coverage
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	$0.00 Copayment		No Coverage
Dialysis	100% - 0%[1]		No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	100% - 0%[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*).	$0.00 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*).	100% - 0%[1,3]		No Coverage
High-Tech Imaging Services – Outpatient Imaging Services: • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	$0.00 Copayment[2]		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.

	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
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
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	$0.00 Copayment per day[2], maximum of $0.00 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*).	100% - 0%[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	$0.00 Copayment per day[2], maximum of $0.00 per Admission		No Coverage
Mental Health/Substance Use Disorder – Office Visits and Outpatient Treatment (*other than Intensive Outpatient Programs*).	$0.00 Copayment per Visit		No Coverage
Newborn – Sick, Services excluding Facility	100% - 0%[1]		No Coverage
Newborn – Sick, Facility	$0.00 Copayment per day[2], maximum of $0.00 per Admission		No Coverage
Oral Surgery	100% - 0%[1,2]		No Coverage
Pregnancy Care – Physician Services	$0.00 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. *refer to the Preventive and Wellness Article in the Benefit Plan*).	100% - 0%[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
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational *(Limited to 50 visits Combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50)* *(Visit limits are combination of Network and Non-Network Benefits; visit limits do not apply when services are provided for Autism Spectrum Disorders).*	$0.00 Copayment per Visit		No Coverage
Skilled Nursing Facility – Network (*limit of 90 days per Plan Year*).	$0.00 Copayment per day[2], maximum of $0.00 per Admission		No Coverage
Sonograms and Ultrasounds (*Outpatient*).	$0.00 Copayment		No Coverage
Urgent Care Center	$0.00 Copayment		No Coverage
Vision Care (*Non-Routine*) Exam	$0.00/$0.00 Copayment depending on Provider		No Coverage
X-Ray (*Low-Tech Imaging*) and Laboratory Services	Office or Independent Lab 100% - 0% 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 and Emergency 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 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 (no Benefit without Prior Authorization)
- Applied Behavior Analysis
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (Shoulder & Knee) *
- Bariatric Surgery Benefit (Enrollment & Surgery)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300.00)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic or Molecular Testing
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (including but not limited to defibrillators)
- Infusion Therapy – includes home and facility administration (exception: Physician's office, unless the drug to be infused may require Authorization)
- Intensive Outpatient Programs
- Interventional Spine Pain Management*
- Joint Replacement (Hip, Knee, & Shoulder) *
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee*
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician's office)
- Orthotic Devices (greater than $300.00)
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions (such as Coronary Stents and Balloon Angioplasty) *
- PET Scans
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300.00)
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers
- Resting Transthoracic Echocardiography*
- Sleep Studies (except those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Urinary Dysfunction or Sexual Dysfunction Resulting from Cancer or Cancer Treatment (Including penile implants)
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

*Part of the MSK (Pain, Spine, Joint), Radiation Oncology and Cardiac Programs

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:

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

OGB'S Pharmacy Benefit Manager

CVS Caremark Formulary: 4-Tier Plan Design

OGB's Pharmacy Benefit Manager for the 2025 Plan year is CVS Caremark. OGB will use the CVS Caremark 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 Copayment or Coinsurance. 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.

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 CVS Caremark website at **www.caremark.com** or **https://info.groupbenefits.org/** or call CVS Caremark member services at 1-877-300-1906, 1-888-996-0104 (EGWP), or Pharmacy Help Desk at 1-800-364-6331.