BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

OGB
MAGNOLIA LOCAL

COMPREHENSIVE MEDICAL BENEFIT PLAN
SCHEDULE OF BENEFITS

Network coverage available only in Baton Rouge, New Orleans and Shreveport
Blue Connect and Community Blue

BENEFIT PLAN FORM NUMBER 40HR2028 03/15

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

Network coverage available only in Baton Rouge, New Orleans and Shreveport
Blue Connect and Community Blue

Lifetime Maximum Benefit: **Unlimited**

Benefit Period: ..... 03/01/2015 – 12/31/2015

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 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	$2,500	No Coverage	$1,000	No Coverage
Individual + 1 Dependent	$5,000	No Coverage	$2,000	No Coverage
Family (Individual + 2 or more Dependents)	$7,500	No Coverage	$3,000	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.

Network Coverage

Community Blue and Blue Connect networks in Shreveport, New Orleans and Baton Rouge are available for OGB members.

These plans are ideal for members who live in the parishes within the available networks and don't plan to use out-of-network care. However, out-of-network care is provided in emergencies.

Community Blue is a select, local network designed for members who live in the communities of Baton Rouge (East and West Baton Rouge and Ascension parishes) or Shreveport (Caddo and Bossier parishes).

Blue Connect is a select, local network designed for members who live in the New Orleans community (Orleans and Jefferson parishes).

COPAYMENTS and COINSURANCE

	NETWORK PROVIDERS		NON-NETWORK PROVIDERS
Physician Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	$25 Copayment per Visit		No Coverage
Allied Health/Other Professional Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants	$25 Copayment per Visit		No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	$50 Copayment per Visit		No Coverage
Ambulance Services – Ground	$50 Copayment		No Coverage
Ambulance Services – Air	$250 Copayment[2]		No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	$100 Copayment[2]		No Coverage
Autism Spectrum Disorders (ASD)	$25/$50 Copayment[3] per Visit depending on Provider		No Coverage
Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%		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**
Cardiac Rehabilitation (*limit of 48 visits per Plan Year*)	$25/$50 Copayment per day depending on Provider $50 Copayment – Outpatient Facility[2]		No Coverage
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	Office – $25 Copayment per Visit Outpatient Facility 100% - 0%[1,2]		No Coverage
Diabetes Treatment	80% - 20%[1]		No Coverage
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	$25 Copayment		No Coverage
Dialysis	100% - 0%[1,2]		No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year		No Coverage
Emergency Room (*Facility Charge*)	$150 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 months following cataract surgery*)	Eyeglass Frames – Limited to a Maximum Benefit of $50[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
Hearing Impaired Interpreter expense	100% - 0%[1]		No Coverage
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET/SPECT Scans	$50 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

	COPAYMENTS and COINSURANCE		
	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 (*allergy and allergy serum*)	100% - 0%[1]		No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable	100% - 0%[1]		No Coverage
Mastectomy Bras – Ortho-Mammary Surgical (*limited to two (2) per Plan Year*)	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year		No Coverage
Mental Health/Substance Abuse – Inpatient Treatment	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Mental Health/Substance Abuse – Outpatient Treatment	$25 Copayment per Visit		No Coverage
Newborn – Sick, Services excluding Facility	100% - 0%[1]		No Coverage
Newborn – Sick, Facility	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Oral Surgery (*Authorization not required when performed in Physician's office*)	100% - 0%[1,2]		No Coverage
Pregnancy Care – Physician Services	$90 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

[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**
Rehabilitation Services – Outpatient: • Physical/Occupational (*Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.*) • Speech • Cognitive • Hearing Therapy	$25 Copayment per Visit		No Coverage
Skilled Nursing Facility – Network (*limit of 90 days per Plan Year*)	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Sonograms and Ultrasounds (*Outpatient*)	$50 Copayment		No Coverage
Urgent Care Center	$50 Copayment		No Coverage
Vision Care (Non-Routine) Exam	$25/$50 Copayment depending on Provider		No Coverage
X-ray and Laboratory Services (*low-tech imaging*)	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, TISSUE AND BONE MARROW TRANSPLANTS

Authorization is Required Prior to Services Being Performed

Organ, Tissue and Bone Marrow Transplants and evaluation for a Plan Participant's suitability for Organ, Tissue 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

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, the Plan will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary.

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Plan Participant must pay all charges incurred.

If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the Network status of the Provider rendering the services.

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. 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 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. The Plan Participant remains responsible for any applicable Copayment or Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

If 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 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 services and supplies require Authorization prior to the services being rendered or supplies being received. Requests for Authorization must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

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

Authorization of Outpatient Services, Including Other Services and Supplies:

If a Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

If Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable. 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 services and supplies require Authorization prior to the services being rendered or supplies being received. Requests for Authorization must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

- Air Ambulance – Non Emergency
- Applied Behavior Analysis
- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Day Rehabilitation Programs
- Dialysis
- 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
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician's office)
- Organ Transplant Evaluation
- Orthotic Devices (Greater than $300.00)
- Outpatient surgical procedures not performed in a Physician's office
- Outpatient non-surgical procedures (Exceptions: X-rays, lab work, Speech Therapy and Chiropractic Services do not require prior Authorization. Non-surgical procedures performed in a Physician's office do not require prior Authorization).
- Outpatient pain rehabilitation or pain control programs
- Partial Hospitalization Programs
- PET/SPCET Scans
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (Greater than $300.00)
- Residential Treatment Centers
- Sleep Studies
- Specialty Pharmacy (Complete list of drugs available online at www.bcbsla.com> I'm a Provider>Pharmacy Management>Specialty Pharmacy Program Drug List.pdf)
- 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 of these five(5) chronic health conditions – diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). (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 five 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 5 chronic health conditions.

b. OGB Plan Participants participating in the program qualify for $20 Copayment (31 day supply), $40 Copayment (62 day supply) or $50 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 Copayment (31 day supply), $80 Copayment (62 day supply) or $100 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.

d. 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 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 these five 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 medical plan, and under the pharmacy plan 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 pharmacy benefits will be provided by OGB'S PBM.

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 will begin using the MedImpact Formulary to help Plan Participants select the most appropriate, lowest-cost options. The formulary is reviewed on a quarterly basis to reassess 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-payment 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.

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

PRESCRIPTION DRUG	PLAN PARTICIPANT PAYS
Generic	50% up to $30
Preferred	50% up to $55
Non-Preferred	65% up to $80
Specialty	50% up to $80
The pharmacy out-of-pocket maximum has been changed from $1,200 to $1,500. Once met:	
Generic	$0 co-pay
Preferred	$20 co-pay
Non-Preferred	$40 co-pay
Specialty	$40 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.

Compound Drugs

Compound Drugs over $400 require prior Authorization from MedImpact.

90-day fill option at retail or mail order network pharmacies

For maintenance medications, 90-day prescriptions fills may be filled for the applicable coinsurance with a maximum that is two and a half times the maximum copayment. For example, if your share of the cost of a generic drug is $30, you can fill your 30-day prescription for $30 or a 90-day prescription for $75.

Over-the-counter drugs
Medications available over-the-counter in the same prescribed strength will no longer be covered under the pharmacy plan.

What is a formulary?

A formulary is a list of medications available to Plan Participants under the Plan's pharmacy benefit. Inclusion on the list is based on consideration of a medication's safety, effectiveness and associated clinical outcomes. The formulary is updated regularly and divides drugs into four main categories: generic, preferred brand, non-preferred brand, and specialty.

- A generic drug is effectively equivalent to a brand name drug in intended use, dosage, strength, and safety. For a generic drug to be approved by the FDA, it must meet the same quality standards as the brand name product. Even the generic manufacturing, packaging, and testing sites must meet the same standards. Many generics are produced in the same manufacturing plant as their branded counterparts.

- Preferred brand drugs are generally those that have been on the market for a while and do not have a generic equivalent available. They are effective alternatives to other brands that may be more expensive.

- Non-preferred brand drugs are recently branded medications. In most cases, a lower cost alternative is available.

- Specialty medications – higher cost drugs.

1. In the event the Plan Participant does not present his identification card to the Network pharmacy at the time of purchase, the Plan Participant will be responsible for full payment for the drug and must then file a claim with the Pharmacy Benefits Manager for reimbursement. Reimbursement is limited to the rates established for Non-Network pharmacies.

   If a Plan Participant chooses a Brand-Name Drug for which an FDA-approved Generic version is available, the Plan Participant pays the difference between the Brand-Name and Generic cost, plus a $40 Copayment for a 31 day supply.

2. Regardless of where the Prescription Drug is obtained, Eligible Expenses for Brand Name Drugs will be limited to:

   a. The Pharmacy Benefits Manager's maximum Allowable Charge for the Generic, when available; or

   b. The Pharmacy Benefits Manager's maximum Allowable Charge for the Brand Drug dispensed, when a Generic is not available.

   c. There is no per prescription maximum on the Plan Participant's responsibility for payment of costs in excess of the Eligible Expense. Plan Participant payments for such excess costs are not applied toward satisfaction of the annual Out-of-Pocket threshold (above).

3. This Plan allows Benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by the PBM.

4. Retirees with Medicare will be automatically enrolled in OGB's Medicare Part D coverage with a commercial wrap benefit.

5. In addition, this Plan allows Benefits limited to $200.00 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are Medically Necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to Coinsurance and Copayments relating to Prescription Drug Benefits. In connection with this Benefit, the following words shall have the following meanings:

   a. "Inherited metabolic disease" shall mean a disease caused by an inherited abnormality of body chemistry and shall be limited to:

      • Phenylketonuria (PKU)
      • Maple Syrup Urine Disease (MSUD)
      • Methylmalonic Acidemia (MMA)
      • Isovaleric Adicemia (IVA)
      • Propionic Acidemia
      • Glutaric Acidemia

- Urea Cycle Defects
- Tyrosinemia

b. "Low protein food products" mean food products that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include natural foods that are naturally low in protein.

6. Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a Physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are not subject to the Prescription Drug deductible and are covered at 100%.

   Smoking cessation screening and counseling are covered under the Preventive or Wellness Care section of this Plan.

7. The following drugs, medicines, and related services and supplies are not covered:

   - Drugs used to treat anorexia, weight loss or weight gain
   - Drugs used to promote fertility
   - Dietary supplements;
   - Medical Foods
   - Bulk Chemicals
   - Drugs for cosmetic purposes or to promote hair growth
   - Nutritional or parenteral therapy;
   - Vitamins and minerals;
   - Drugs available over the counter (OTC) (unless expressly covered by this Plan)
   - Prescription drugs (federal legend) with an OTC equivalent

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