Louisiana

OGB
MAGNOLIA OPEN ACCESS

COMPREHENSIVE PPO MEDICAL BENEFIT PLAN
SCHEDULE OF BENEFITS

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

BENEFIT PLAN FORM NUMBER 40HR1695 R01/21

PLAN NAME
State of Louisiana Office of Group Benefits

PLAN NUMBER
ST222ERC

PLAN'S ORIGINAL BENEFIT PLAN DATE
January 1, 2013

PLAN'S ANNIVERSARY DATE
January 1st

Lifetime Maximum Benefit: ..... **Unlimited**

Benefit Period: ..... 01/01/2021 – 12/31/2021

DEDUCTIBLE AMOUNT PER BENEFIT PERIOD:

Individual:

Network Providers:	
Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)	$900.00
Retirees prior to 03/01/15 (With and Without Medicare)	$300.00
Non-Network Providers:	
Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)	$900.00
Retirees prior to 03/01/15 (With and Without Medicare)	$300.00

Individual + 1 Dependent:

Network Providers:	
Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)	$1,800.00
Retirees prior to 03/01/15 (With and Without Medicare)	$600.00
Non-Network Providers:	
Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)	$1,800.00
Retirees prior to 03/01/15 (With and Without Medicare)	$600.00

Family (Individual + 2 or more Dependents):

Network Providers:

Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)	$2,700.00
Retirees prior to 03/01/15 (With and Without Medicare)	$900.00

Non-Network Providers:

Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)	$2,700.00
Retirees prior to 03/01/15 (With and Without Medicare)	$900.00

SPECIAL NOTES

Deductible Amounts

Active and Retirees on or after March 1, 2015:

Eligible Expenses for services of a Network Provider that apply to the Deductible Amount for Network Providers **will not** accrue to the Deductible Amount for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Deductible Amounts for Non-Network Providers **will not** accrue to the Deductible Amount for Network Providers.

Retirees With or Without Medicare Prior to March 1, 2015:

The Deductible Amount is a single amount that includes eligible charges incurred from all Providers combined.

OUT-OF-POCKET AMOUNT PER BENEFIT PERIOD:

Includes all eligible Medical and Pharmacy Copayments, Coinsurance Amounts, and Deductibles					
	Active Employee/Retirees on or after March 1, 2015		**Retirees prior to March 1, 2015 without Medicare**		**Retirees prior to March 1, 2015 with Medicare**
	Network	**Non-Network**	**Network**	**Non-Network**	**Network and Non-Network**
Individual Only	$3,500.00	$4,700.00	$2,300.00	$4,300.00	$3,300.00
Individual Plus One (Spouse or Child)	$6,000.00	$8,500.00	$3,600.00	$7,600.00	$5,600.00
Individual Plus Two	$8,500.00	$12,250.00	$4,900.00	$10,900.00	$7,900.00
Individual Plus Three	$8,500.00	$12,250.00	$5,900.00	$13,700.00	$9,900.00
Individual Plus Four	$8,500.00	$12,250.00	$6,900.00	$13,700.00	$11,900.00
Individual Plus Five	$8,500.00	$12,250.00	$7,900.00	$13,700.00	$13,700.00
Individual Plus Six	$8,500.00	$12,250.00	$8,900.00	$13,700.00	$13,700.00
Individual Plus Seven	$8,500.00	$12,250.00	$9,900.00	$13,700.00	$13,700.00
Individual Plus Eight	$8,500.00	$12,250.00	$10,900.00	$13,700.00	$13,700.00
Individual Plus Nine	$8,500.00	$12,250.00	$11,900.00	$13,700.00	$13,700.00
Individual Plus Ten	$8,500.00	$12,250.00	$12,900.00	$13,700.00	$13,700.00
Individual Plus Eleven or More	$8,500.00	$12,250.00	$13,700.00	$13,700.00	$13,700.00

SPECIAL NOTES

Out-of-Pocket Amounts

Active and Retirees on or after March 1, 2015:

Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Amount for Network Providers **will not** accrue to the Out-of-Pocket Amount for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Amount for Non-Network Providers **will not** accrue to the Out-of-Pocket Amount for Network Providers.

Retirees With Medicare Prior to March 1, 2015:

The Out of Pocket Amount is a single amount that includes eligible charges incurred from all Providers combined.

When the Out-of-Pocket Amounts, as shown above, have been satisfied, this Plan will pay 100% of the Allowable Charge toward Eligible Expenses for the remainder of the Plan Year.

Retirees Without Medicare Prior to March 1, 2015:

Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Amount for Network Providers **will** accrue to the Out-of-Pocket Amount for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Amount for Non-Network Providers **will** accrue to the Out-of-Pocket Amount for Network Providers.

When the Out-of-Pocket Amounts, as shown above, have been satisfied, this Plan will pay 100% of the Allowable Charge toward Eligible Expenses for the remainder of the Plan Year.

There may be a significant Out-of-Pocket expense to the Plan Participant when services are received from a Non-Network Provider.

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 assigns Eligibility for all Plan Participants.

COINSURANCE/COPAYMENT

	ACTIVE EMPLOYEES/NON-MEDICARE RETIREES		RETIREES WITH MEDICARE
	Network Providers	Non-Network Providers	Network and Non-Network/Providers
Physician Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics • Geriatrics	90%-10%[1]	70% - 30%[1]	80% - 20%[1]
Allied Health/Other Professional Visits: • Chiropractor • Nurse Practitioner • Retail Health Clinic • Osteopath • Physician Assistant	90%-10%[1]	70% - 30%[1]	80% - 20%[1]
Specialist (Physician) Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietitian • Sleep Disorder Clinic	90%-10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulance Services - Ground	90%-10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulance Services - Air Non-emergency requires prior authorization[2]	90%-10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	90%-10%[1]	70% - 30%[1]	80% - 20%[1]
Birth Control Devices - Insertion and Removal (*As listed in the Preventive and Wellness Care Article in the Benefit Plan.*)	100% - 0%	70% - 30%[1]	Network Providers 100% - 0% Non-Network Providers 80% - 20%[1]
Cardiac Rehabilitation (*Must begin within six (6) months of qualifying event; Limited to 36 visits per Plan Year)*	90%-10%[1,2,3]	70% - 30%[1,2,3]	80% - 20%[1,3]
Chemotherapy/Radiation Therapy	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Diabetes Treatment	90% -10%[1]	70% - 30%[1]	80% - 20%[1]

[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

COINSURANCE/COPAYMENT

	ACTIVE EMPLOYEES/NON-MEDICARE RETIREES		RETIREES WITH MEDICARE
	Network Providers	Non-Network Providers	Network and Non-Network/Providers
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	90% -10%[1]	Not Covered	80% - 20%[1]
Dialysis	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Emergency Room (*Facility Charge*)	$150.00 Copayment; Waived if Admitted		
	90% -10%[1]	90% -10%[1]	80% - 20%[1]
Emergency Medical Services (*Non-Facility Charges*)	90% -10%[1]	90% -10%[1]	80% - 20%[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]		
Flu shots and H1N1 vaccines (*Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%	100% - 0%	100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*)	90% -10%[1,3]	70% - 30%[1,3]	80% - 20%[1,3]
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET Scans	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Home Health Care (*Limit of 60 visits per Plan Year*)	90% -10%[1,2]	70% - 30%[1,2]	Not Covered
Hospice Care (*Limit of 180 days per Plan Year*)	80% -20%[1,2]	70% - 30%[1,2]	Not Covered
Injections Received in a Physician's Office (*When No Other Health Service is Received*)	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Inpatient Hospital Admission, All Inpatient Hospital Services Included			
Per Day Copayment	$0	$50.00	$0
Day Maximum	Not Applicable	5 Days	Not Applicable
Coinsurance	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]

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COINSURANCE/COPAYMENT

	ACTIVE EMPLOYEES/NON-MEDICARE RETIREES		RETIREES WITH MEDICARE
	Network Providers	Non-Network Providers	Network and Non-Network/Providers
Inpatient and Outpatient Professional Services	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%	100% - 0%	100% - 0%
Mastectomy Bras - Ortho-Mammary Surgical (*Limit of three (3) per Plan Year*)	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Mental Health/Substance Use Disorder - Inpatient Treatment and Intensive Outpatient Programs			
Per Day Copayment	$0	$50.00	$0
Day Maximum	Not Applicable	5 Days	Not Applicable
Coinsurance	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Mental Health/Substance Use Disorder – Office Visits and Outpatient Treatment (Other than Intensive Outpatient Programs)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn – Sick, Services Excluding Facility	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn – Sick, Facility			
Per Day Copayment	$0	$50.00	$0
Day Maximum	Not Applicable	5 Days	Not Applicable
Coinsurance	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Oral Surgery	90% 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Pregnancy Care – Physician Services	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
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 Care Article in the Benefit Plan.)	100% -0%[3]	70% - 30%[1,3]	Network - 100% - 0[3] Non-Network 80% - 20%[1,3]

[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

COINSURANCE/COPAYMENT

	ACTIVE EMPLOYEES/NON-MEDICARE RETIREES		**RETIREES WITH MEDICARE**
	Network Providers	Non-Network Providers	Network and Non-Network/Providers
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational *(Combined limit of 50 Visits 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)*	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Skilled Nursing Facility *(Limit of 90 days per Plan Year)*	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Sonograms and Ultrasounds (*Outpatient*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Urgent Care Center	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Vision Care (Non-Routine) Exam	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
X-ray (Low-Tech Imaging) and Laboratory Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]

[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.

Benefits are subject to the Deductible and Coinsurance and Inpatient Facility Copayments.

Active Employees and Non-Medicare Retirees:

Network Providers: ..... 90% - 10%
Non-Network Providers: ..... 70% - 30%

Retirees with Medicare:

Network/Non-Network Providers: ..... 80% - 20%

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, 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 as shown below.

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.

If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce the Allowable Charge by **Twenty-Five Percent (25%)**. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Copayment or Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

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 from a BlueCard® Worldwide provider 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 from a non-BlueCard® Worldwide provider **are covered at the Non-Network Benefit level.**

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.

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

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)*
- 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
- 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)
- Insulin Pumps
- 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*
- 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.

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.

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 $40.00 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.

Authorizations

The following Prescription Drug categories require Prior Authorization. The Plan Participant's Physician must call 1-800-842-2015 to obtain Authorization. The Plan Participant or his Physician should call the Customer Service number on the back of the ID card, or go to 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 Provider: ..... 100% - 0%
Non-Network Provider: ..... 70% - 30% (After Deductible is Met)

OGB'S Pharmacy Benefits Manager

MedImpact Formulary: 3-Tier Plan Design

OGB's Pharmacy Benefit Manager for the 2021 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 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 website at **https://mp.medimpact.com/ogb** or **www.groupbenefits.org** or call MedImpact member services at 1-800-910-1831.