



BlueCross BlueShield of Louisiana

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

HMO PLAN FOR STATE OF LOUISIANA OFFICE OF GROUP BENEFITS

GROUP

State of Louisiana, Office of Group Benefits

GROUP NUMBER

ST222ERC

GROUP'S ORIGINAL BENEFIT PLAN DATE

July 1, 2010

GROUP ANNIVERSARY DATE

July 1st

SCHEDULE OF BENEFITS

Lifetime Maximum Benefit

Unlimited

Benefit Period

The Benefit Period is a short period, July 1, 2011 through December 31, 2011. For Members joining the Plan on or after July 1, 2011, the Benefit Period begins on the Member's Effective Date and ends on December 31, 2011.

For Members covered on this Plan during the prior Benefit Period, July 1, 2010 through June 30, 2011, the amounts accrued toward the Member's Deductible and Out-of-Pocket Maximum will be applied to this short Benefit Period ending on December 31, 2011.

The next Benefit Period will begin January 1, 2012 and end December 31, 2012, and will be on a calendar year basis thereafter. All Deductibles and Out-of-Pocket amounts must be met beginning on January 1, 2012.

DEDUCTIBLE/OUT-OF-POCKET AMOUNTS

| | NETWORK PREFERRED CARE | NON-NETWORK ALL OTHER PROVIDERS |
|----------------------------------|---------------------------|------------------------------------|
| Benefit Period Deductible | \$0 | \$1,000 |
| Family Benefit Period Deductible | \$0 | \$3,000 |
| Out-Of-Pocket Amount | \$1,000 | \$3,000 |
| Family Out-of-Pocket Amount | \$3,000 | \$9,000 |

When the amount of combined eligible expenses paid by the Member satisfies the Deductible and separate Out-of-Pocket limits as shown above, this Benefit Plan will pay 100% of the allowable charge toward eligible expenses for the remainder of the plan year, unless specifically indicated, subject to any Plan Year maximums and the lifetime maximum of the Benefit Plan.

If the Member uses a combination of Network and Non-Network Providers, Non-Network Benefits will reduce the Network Out-of-Pocket maximum; however, Network Benefits will not reduce the Non-Network Out-of-Pocket maximum. Organ, Tissue and Bone Marrow Transplants, penalties, Durable Medical Equipment, Prostheses, routine Vision Care Copayment, Orthotics and Deductibles are not applied to the individual or family Out-of-Pocket limits.

COPAYMENTS and COINSURANCE

| | NETWORK PREFERRED CARE | NON-NETWORK ALL OTHER PROVIDERS |
|---|--|--|
| | <i>Copayments shown are the Member's responsibility; Coinsurance shown as Company-Member responsibility payable after Deductible is met.</i> | |
| Physician's Office Visits | \$15/\$25 copay per visit depending on Provider | 70% - 30% |
| Physician's Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioner • Physician's Assistant | \$15 copay per visit | 70% - 30% |
| Specialist's Office Visits including surgery performed in an office setting. <ul style="list-style-type: none"> • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic | \$25 copay per visit | 70% - 30% |
| Alopecia – limited to two (2) office visits per plan year (<i>lab services covered at coinsurance amounts when performed on same day as office visit and by same Provider</i>). | 100% - 0% | 70% - 30% |
| Ambulance Services (for Emergency Medical Transportation only). <ul style="list-style-type: none"> • Ground Transportation • Air Ambulance | \$50 copay \$250 copay | \$50 copay \$250 copay |
| Ambulatory Surgical Center and Outpatient Surgical Facility | \$100 copay | 70% - 30% |
| Birth Control Devices (insertion & removal) | \$15/\$25 copay depending on Provider | 70% - 30% |
| Contraceptive Implant Systems | 90% - 10% | 70% - 30% |
| Cardiac Rehabilitation (limited to 48 visits per plan year). <ul style="list-style-type: none"> • Office Visit • Outpatient Facility | \$15/\$25 per day depending on Provider \$25 copay | 70% - 30% 70% - 30% |
| Chemotherapy <ul style="list-style-type: none"> • Office Visit • Outpatient Facility | \$15 copay 100% - 0% | 70% - 30% 70% - 30% |
| Diabetes Treatment | 80% -20% | 70% - 30% |

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| Diabetic/Nutritional Counseling (clinics & outpatient facilities) | \$15 copay | 70% - 30% |
| Dialysis | 100% - 0% | 70% - 30% |
| Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices | 80% up to \$5,000 allowable, per plan year; then 100% - 0% | 70% - 30% |
| Mastectomy bras - limited to 2 (two) per Plan Year. | Same as DME above. | 70% - 30% |
| Emergency Room (facility charge) | \$100 copay; waived if admitted | \$100 copay; waived if admitted |
| Flu shots and H1N1 vaccines administered at In-Network Providers, Out-of-Network Providers, Pharmacy, job site or health fair. | 100% - 0% | 100% - 0% |
| Hearing Aids (limited to a maximum benefit of \$1,400 per hearing aid every 36 months, for Members age 17 and under) | 80% - 20% | Not Covered |
| Hearing Impaired Interpreter Expense | 100% - 0% | Not Covered |
| High-Tech Imaging (Outpatient) <ul style="list-style-type: none"> • CT/CAT Scans • MRA/MRI • Nuclear Cardiology • PET/SPECT Scans | \$50 copay | 70% - 30% |
| Home Health Care, limited to 150 visits per plan year. (In-Network and Non-Network Providers aggregate to the 150 visit maximum). Not covered when Medicare is primary. | 100% - 0% | 70% - 30% |
| Hospice Care is not covered when Medicare is primary. | 100% - 0% | 70% - 30% |
| Infertility Diagnosis (Benefit is for the initial office visit only. There is no infertility treatment benefit.) | \$15/\$25 copay depending on Provider | 70% - 30% |
| Inpatient Hospital Admission, all Inpatient Hospital services included. | \$100 per day - Maximum of \$300 per admission | 70% - 30% |
| Inpatient and Outpatient professional services for which a copayment is not applicable. | 100% - 0% | 70% - 30% |

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| Mental Health Services (Medical Visit Only; payable by Blue Cross and Blue Shield of Louisiana.) | \$15/\$25 copay depending on Provider | 70% - 30% |
| Services for a Mental Health diagnosis are payable for Non-Psychiatric Providers only. Limited to one (1) visit per plan year. Refer to the Mental Disorders/Substance Abuse Article of the Benefit Plan for more information. | | |
| NEWBORNS: | | |
| Well Newborn (initial inpatient hospital stay) | 100% - 0% | 70% -30% |
| Sick Newborn Services, excluding Facility | 100% - 0% | 70% - 30% |
| Sick Newborn - Facility | \$100 per day. Maximum of \$300 per admission | 70% -30% |
| <u>Oral Surgery</u> | \$25 copay | 70% - 30% |
| Pregnancy Care - Physician's Services Services from other Providers such as a Hospital, and Urgent Care Center are subject to the applicable copays and coinsurance shown for each. | \$90 per pregnancy | 70% - 30% |
| Preventive* & Wellness/Routine Care | 100% - 0% | 70% - 30% |
| Radiation Therapy | \$15 copay | 70% - 30% |
| • Office Visit | 100% - 0% | 70% - 30% |
| • Outpatient Facility | | |
| Rehabilitative Care – Physical, Speech, Occupational, Cognitive and Hearing Therapy | \$15 per visit regardless of Provider type or location | 70% - 30% |
| Skilled Nursing Facility, limited to 120 days per plan year. (In-Network and Non-Network Providers aggregate to the 120 day maximum) | \$100 per day. Maximum of \$300 per admission | 70% - 30% |
| Sonograms & Ultrasounds (Outpatient) | \$25 copay | 70% - 30% |
| Urgent Care Center | \$25 copay | 70% - 30% |
| Vision Care (non-routine) Exam | \$15/\$25 depending on Provider | 70% -30% |
| Vision Care (routine) Exam - Limited to one (1) exam per plan year. Not covered when Medicare is primary. | \$15/\$25 depending on Provider | Not covered |
| Eyeglass frames and one pair of eyeglass lenses or one pair of contact lenses - (purchased within 6 months following cataract surgery). Expenses incurred for the eyeglass frames are limited to a maximum benefit of \$50. | | |
| X-ray and Laboratory Services | 100% -0% | 70% - 30% |

* More information provided in ARTICLE VI: Preventive or Wellness (Routine) Care.

ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

In-Network Benefits Only

100% - 0%

- Benefits are subject to the office visit and inpatient facility copayments.
- Organ, Tissue and Bone Marrow Transplants and evaluation for a Member's suitability for Organ, Tissue Bone Marrow transplants will not be covered unless a Member obtains written authorization from Blue Cross and Blue Shield of Louisiana, prior to services being rendered.
- Covered expenses for Organ Transplants do not aggregate to the Out-of-Pocket maximums.
- Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

AUTISM SPECTRUM DISORDERS (ASD)

ASD Benefits are paid the same as any other illness.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

BLUE CROSS AND BLUE SHIELD OF LOUISIANA DOES NOT PROVIDE CLAIMS PAYMENT SERVICES FOR THE FOLLOWING MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS.

The following is a brief summary of your Mental Health and Substance Abuse Benefits which are provided by OGB's Mental Health and Substance Abuse Benefit Administrator. For more information, and to obtain prior approval for services, please call 866-492-7143.

| Member Out-of-Pocket Expenses: | <u>Inpatient Treatment*</u> | <u>Outpatient Treatment*</u> |
|--------------------------------|--|------------------------------|
| | \$100 per day copayment - \$300 maximum per admit | \$15 per visit copay |

PRECERTIFICATION REQUIRED

No separate Mental Health and Substance Abuse Deductible for Inpatient or Outpatient Treatment.

**Member will owe Deductible, Copayment, Coinsurance and balance of billed charges.*

AUTHORIZATION OF INPATIENT ADMISSIONS

SERVICES ARE NOT COVERED IF AUTHORIZATION IS NOT OBTAINED PRIOR TO SERVICES BEING RENDERED.

All Elective, Non-Emergency and Emergency Inpatient Hospital Admissions (except routine maternity stays) require Authorization from Blue Cross and Blue Shield of Louisiana. Refer to Authorization of Services and Supplies and if applicable, Pregnancy Care Benefits in the Benefit Plan for complete information.

Requests for Authorization of Inpatient Admissions, 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 1-800-523-6435. In some cases, In-Network Benefits may be paid to Non-Network Providers whose services are not available by an In-Network-Provider. **PRIOR AUTHORIZATION IS REQUIRED.** The In-Network Benefits will be based on the maximum allowable amount. The Member can be balance-billed.

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States (out of country) are covered at the In-Network benefit level. Non-emergency services received outside of the United States (out of country) **are covered at the Out-of-Network benefit level.**

**AUTHORIZATION OF OUTPATIENT SERVICES,
INCLUDING OTHER COVERED SERVICES AND SUPPLIES**

SERVICES ARE NOT COVERED IF AUTHORIZATION IS NOT OBTAINED PRIOR
TO SERVICES BEING RENDERED.

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

- Applied Behavioral Analysis
- Bone Growth Stimulator
- CT/CAT Scans (not required when performed in an observation setting of a hospital)
- Day Rehabilitation Programs
- Durable Medical Equipment (DME) greater than \$750
- Electric & Custom Wheelchair
- Home Health Care
- Hospice Care
- Hyperbarics
- Implantable Medical Devices over \$2000 such as Implantable Defibrillator and Insulin Pump
- MRI/MRA (not required when performed in an observation setting of a hospital)
- Non-Emergency Air Ambulance
- Nuclear Cardiology (not required when performed in an observation setting of a hospital)
- PET Scans/SPECT Scans (not required when performed in an observation setting of a hospital)
- Prosthetic Appliances
- Residential Treatment Center
- Skilled Nursing Facility
- Sleep Studies
- Speech Therapy
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Transplant Evaluations and procedures
- Vacuum Assisted Wound Closure Therapy

PRE-EXISTING CONDITION EXCLUSION PERIOD

The exclusion for a Pre-Existing Condition is applicable as stated in the “Limitations and Exclusions” article of the Benefit Plan. Refer to the Benefit Plan for complete information.

ELIGIBILITY

The Group assigns Eligibility to all Members.

PRESCRIPTION DRUG BENEFITS

Blue Cross and Blue Shield of Louisiana does not provide claims payment services for prescription drugs except for those prescription drugs administered during an Inpatient or Outpatient stay or those medically necessary/non-investigational drugs requiring parenteral administration in a physician’s office. **All other pharmacy benefits will be provided by OGB’s Pharmacy Benefit Administrator.**

BLUE CROSS AND BLUE SHIELD OF LOUISIANA IS NOT RESPONSIBLE FOR THE CONTENT OF THE FOLLOWING INFORMATION. ANY QUESTIONS, COMMENTS OR CONCERNS REGARDING THE FOLLOWING PRESCRIPTION DRUG BENEFITS SHOULD BE ADDRESSED DIRECTLY TO OGB'S PHARMACY BENEFIT ADMINISTRATOR, BY CALLING 866-358-9530.

This Plan allows Benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription and are dispensed by a licensed pharmacist or pharmaceutical company.

1. These include and shall not be limited to:
 - a. Insulin;
 - b. Retin-A dispensed for Covered Persons under the age of 27;
 - c. Vitamin B12 injections;
 - d. Prescription Potassium Chloride; and
 - e. Over-the-counter diabetic supplies including, but not limited to, strips, lancets, and swabs.
2. In addition, this Plan allows Benefits limited to \$200 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.

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

- Appetite suppressant drugs;
- Dietary supplements;
- Topical forms of Minoxidil;
- Retin-A dispensed for a Covered Person over age 26;
- Amphetamines dispensed for diagnoses other than Attention Deficit Disorder or Narcolepsy;
- Nicotine, gum, patches, or other products, services, or programs intended to assist an individual to reduce or cease smoking or other use of tobacco products;
- Nutritional or parenteral therapy;
- Vitamins and minerals;
- Drugs available over the counter;
- Serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting;
- Drugs prescribed for treatment of impotence, except following the surgical removal of the prostate gland;

- Glucometers.

Outpatient prescription drug benefits are adjudicated by a third-party Prescription Benefits Manager with whom the Program has contracted. In addition to all provisions, exclusions, and limitations relative to prescription drugs set forth elsewhere in this Plan, the following apply to expenses incurred for outpatient prescription drugs:

1. Upon presentation of the Group Benefits Program Health Benefits Identification Card at a network pharmacy, the plan member will be responsible for payment of 50 percent of the cost of the drug, up to \$50 per prescription dispensed. The plan will pay the balance of the eligible expense for prescription drugs dispensed at a network pharmacy. However, when a generic is available but a brand drug is dispensed, the member will be responsible for payment of the full amount of excess cost (the difference between the brand and generic costs) in addition to the 50 percent of the cost of the drug, up to \$50 per prescription dispensed. There is a \$1,200 per person per plan year Out-of-Pocket threshold for eligible prescription drug expenses. Once this threshold is reached, that is, the plan member has paid \$1,200 of Coinsurance/Copayments for eligible prescription drug expenses, the plan member will be responsible for a \$15 copay for brand name drugs, with no copay for generic drugs. The plan will pay the balance of the eligible expense for prescription drugs dispensed at a network pharmacy.
2. In the event the Plan Member does not present his identification card to the network pharmacy at the time of purchase, the Plan Member will be responsible for full payment for the drug and must then file a claim with the prescription Benefits manager for reimbursement. Reimbursement is limited to the rates established for non-network pharmacies.
3. If the Plan Member obtains a prescription drug from a non-network pharmacy in state, reimbursement will be limited to 50% of the amount that would have been paid if the drug had been dispensed at a network pharmacy. If the Plan Member obtains a prescription drug from a non-network pharmacy out of state, Benefits will be limited to 80% of the amount that would have been paid if the drug had been dispensed at a network pharmacy.
4. Regardless of where the prescription drug is obtained, eligible expenses for brand name drugs will be limited to:
 - a. The Prescription Benefits Manager's maximum allowable charge for the generic, when available; or
 - b. The Prescription 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 member's responsibility for payment of costs in excess of the eligible expense. Plan member payments for such excess costs are not applied toward satisfaction of the annual out-of-pocket threshold (above).
5. Prescription drug dispensing and refills will be limited in accordance with protocols established by the Prescription Benefits Manager, including the following limitations:
 - a. Up to a 30-day supply of drugs may be dispensed upon initial presentation of a prescription or for refills dispensed more than 120 days after the most recent fill;
 - b. For refills dispensed within 120 days of the most recent fill, up to a 90-day supply of drugs may be dispensed at one time, provided that Copayments shall be due and payable as follows:
 - i. For a supply of 1-30 days, the Plan Member will be responsible for payment of 50% of the cost of the drug, up to a maximum of \$50 per prescription dispensed;
 - ii. For a supply of 31-60 days, the Plan Member will be responsible for payment of 50% of the cost of the drug, up to a maximum of \$100 per prescription dispensed;

- iii. For a supply of 61-90 days, the Plan Member will be responsible for payment of 50% of the cost of the drug, up to a maximum of \$150 per prescription dispensed;
 - iv. Once the out-of-pocket threshold for eligible prescription drug expenses is reached, the Plan Member's Copayment responsibility for brand drugs will be \$15 for a 1-30 day supply, \$30 for a 31-60 day supply, and \$45 for a 61-90 day supply, with no co-pay for up to a 90 day supply of generic drugs.
6. Brand Drug means the trademark name of a drug approved by the U. S. Food and Drug Administration.
7. Generic Drug means a chemically equivalent copy of a brand drug.