Louisiana

# 2020 ANNUAL ENROLLMENT GUIDE

State of Louisiana Employees and Retirees Administered by
Blue Cross and Blue Shield of Louisiana

01MK4360 R09/19

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# Blue Cross and Blue Shield of Louisiana is proud to serve your healthcare needs.

Blue Cross is committed to meeting the challenging demands of healthcare in the 21st century. We work hard every day to bring Blue Cross plan members the high level of service you expect and deserve. Founded in 1934, we are Louisiana's oldest and largest health insurance company.

## Your Blue Plan Features:

- a large network of doctors and hospitals
- physician office visits
- direct access to specialty care without a referral
- member discounts and savings through Blue365®
- a comprehensive wellness and prevention program
- online tools to help you get the most from your health plan
- an ID card recognized around the world
- local customer service

## Ready to Enroll?

- **LaGov* employee** – Log into LEO and select the My Benefits tab and then Annual Enrollment.
  ***NOTE:*** *rehired retirees will need to contact HR for any benefit changes.*
- **Non-LaGov* employee** – Visit the Office of Group Benefits (OGB) online enrollment portal at info.groupbenefits.org and select your benefits.
- **Retiree** – Visit the OGB online enrollment portal at info.groupbenefits.org and select your benefits. Or complete the paper annual enrollment form or contact OGB.

*If you decide not to change your plan for next year, do nothing. You will stay on your current plan in 2020.*

**"LaGov" and "Non-LaGov" are agency classifications used by OGB. If you are uncertain about whether your agency is classified as LaGov or Non-LaGov, contact your human resources department.*

## Customer Service

**www.bcbsla.com/ogb**

**(800) 392-4089**

**ogbhelp@bcbsla.com**

To view the Summary of Benefits and Coverage (SBC), go to www.bcbsla.com/ogb.

This Annual Enrollment Guide is presented for general information only. It is not a benefit plan, nor intended to be construed as the Blue Cross benefit plan document. If there is any discrepancy between this Annual Enrollment Guide and the Blue Cross benefit plan document and Schedule of Benefits, the FINAL Blue Cross benefit plan document and Schedule of Benefits will govern the benefits and plan payments.

# Provider Network

Blue Cross network doctors, hospitals and other healthcare providers have agreed to provide you the care you need at the best price.

To find a doctor in your Blue Cross network:

1. Go to www.bcbsla.com/ogb
2. Click (Choose member type) and select the plan you are interested in from the drop down menu.
3. Click Find a Doctor and then Find a Doctor in This Network. To find a provider for Magnolia Local, select:
   - **Find a Community Blue Doctor:** If you live in Ascension, East Baton Rouge, Livingston or West Baton Rouge parishes.
   - **Find a Blue Connect Doctor:** If you live in Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany or Vermilion parishes.

## Network

Here's what you can expect when you see a doctor or go to a hospital that is in your network:

- You receive the highest level of benefits your health plan has to offer.
- You save money, because the provider has agreed with your health plan upon a discounted rate.
- You won't be billed for the difference between what we pay and what the provider charges for covered services. (Also known as balance billing – see page 57)
- You will be responsible for your coinsurance, copayments and any deductibles that apply under your plan.

## Out-of-Network

Here's what you can expect if you see a doctor or go to a hospital that is not in your network:

- You could pay a higher copayment, deductible and/or coinsurance.
- The doctor or hospital could bill you for the difference between what we pay and what they charge. (Also known as balance billing – see page 57)
- You could receive a penalty or reduction in benefits, depending on your plan.

You may contact Customer Service if you have any trouble finding a network provider or if you have any questions at (800) 392-4089 from 8 a.m. - 8 p.m, Monday – Friday.

## Benefits That Travel

The BlueCard® Program allows our members to receive healthcare services while traveling or living in another Blue Plan's service area. You'll have peace of mind knowing you will find the care you need if you get sick or injured on the road. BlueCard links participating healthcare providers with the independent Blue Plans across the country through a single electronic network.

Search for a provider outside of the state of Louisiana under National Provider Directory by visiting www.bcbsla.com/find-a-doctor and selecting National Medical from the drop down menu, or on the free BCBSLA app for your iPhone or Android.

***NOTE:*** *Magnolia Local members do not have access to the BCBS National BlueCard Providers.*

## The Doctor Will See You Anywhere, Anytime

BlueCare lets you have doctor visits online, without taking time off from work or school. BlueCare is: 24/7 - no appointment needed; open to you and any dependents (children, spouse, etc.) covered on your plan; faster than going to an ER or urgent care; available on a computer, tablet, smartphone or any device with internet; and secure and as legitimate as an in-person visit. It's a safe, fast and affordable way to get a diagnosis and treatment plan for non-emergency conditions like cough and cold, allergies, sinusitis, bladder infections, rashes and more.

You will pay up front at the time of your BlueCare visit. Depending on your plan type and benefits, you may get a refund after your visit. If you do, Blue Cross will mail you the amount you are owed after you have your BlueCare visit. Go to www.bcbsla.com/bluecare to learn more. BlueCare is not meant to replace routine visits to a primary care doctor.

***NOTE:*** *BlueCare is not available to members with Medicare as their primary health coverage.*

## Care Management Programs

Your health is important to us. Our health coaches want to support you in leading a fuller, healthier life. If you have been diagnosed with a serious or long-term health condition, call us to find out how we can help you through our Care Management programs.

### Stronger Than

We know you are stronger than any disease or diagnosis. And we'll work with you to keep you strong. Through our Care Management programs, we can offer you the assistance and expertise of nearly 200 in-house clinical professionals – including nurses, dietitians and social workers. We can talk with you about your health needs and medical history to find a Care Management program that is right for you.

## How Will Health Coaches Help Me?

We will help you work toward your health goals, no matter what the size. Health coaching is personalized, and we will assist you with your unique needs.

**Our health coaches will:**

- Offer tips to stick to the treatment plan your doctor/healthcare provider made for you
- Share information or educational materials about your health condition
- Work with you on areas where you want to make changes, such as quitting smoking, exercising, eating healthy or getting preventive care
- Connect you with in-network healthcare providers in your area
- Send you preventive and wellness care reminders, sometimes along with your doctor's office

**Can you participate in the program?**
As an OGB plan member, you can participate in Blue Cross Care Management programs if you:

- Are enrolled in one of the Blue Cross health plans;
- Do not have Medicare as primary health coverage; and,
- Have been diagnosed with one or more of these ongoing health conditions:
  - Diabetes
  - Coronary artery disease
  - Heart failure
  - Asthma
  - Chronic obstructive pulmonary disease (COPD)

**Call (800) 363-9159 to speak with one of our health coaches, who can help you get started.**

## Authorization of Elective Admissions and Other Covered Services

If you need to be hospitalized for a condition other than an emergency, your admission to the hospital requires authorization. Patients, physicians, hospitals and our Population Health Management Department all participate in the authorization process that is used to determine whether hospitalization is necessary and an appropriate length of stay. Certain services and visits to certain providers require authorization from Blue Cross before services can be performed.

*See page 56 for a list of services and supplies that must be authorized.*

## Continuity of Care

Under special circumstances, such as a high-risk pregnancy or life-threatening illness, Blue Cross may allow members to continue getting their care from a non-network physician or other healthcare practitioner for a specified length of time. Blue Cross members may request a Continuity of Care form by contacting Customer Service at (800) 392-4089 or download the form from our website at www.bcbsla.com/ogb.

# Mental Health and Substance Abuse Benefits

Blue Cross partners with New Directions, experts in providing behavioral health services. New Directions manages the mental health and substance abuse services that are part of your OGB health plan, including outpatient, inpatient, partial hospitalization and residential treatment for mental health and substance abuse problems.

## Receiving the Best Care

New Directions will help you receive high-quality care with your needs in mind—giving you a better experience with:

- **Care Management** – Licensed mental health doctors, nurses and other providers help you find a provider and a treatment plan that will work best for you and your dependents.
- **Coordinated Care** – New Directions works with your health plan to understand your needs and to create treatment programs that will meet those needs.
- **High-Quality Care** – New Directions studies what care works best and compares results to help make your quality of care even stronger.

## Authorizations for Care

Our behavioral health vendor is responsible for all mental health and substance abuse care authorizations. Your doctor or provider must check with New Directions before you receive care.

## Network Providers

You can go to the Blue Cross behavioral health network of doctors for your care. To find out if your doctor is in your Blue Cross behavioral health network, go to www.bcbsla.com/ogb and click Choose member type. Select the plan you are interested in from the drop down menu. Click Find a Doctor and then Find a Doctor in This Network.

To find a provider for Magnolia Local, select Find a Community Blue Doctor if you live in Ascension, East Baton Rouge, Livingston or West Baton Rouge parishes or Find a Blue Connect Doctor if you live in Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany or Vermilion parishes.

# Wellness Resources

## Live Better Louisiana

Live Better Louisiana is OGB's game plan for better health. The program gives Blue Cross members resources to help you better monitor your health, understand risk factors and make educated choices that keep you healthier. Blue Cross and Blue Shield of Louisiana sponsors the program at no extra charge to you.

Live Better Louisiana can also save you money on next year's health insurance premium. Complete a Catapult Health[1] clinic before the end of the program year and you could qualify for a premium credit next year[2]. During this no out-of-pocket cost preventive care visit, learn your health status related to diabetes, heart disease and stroke. Get lab-accurate results in minutes. Review your results with a board-certified nurse practitioner and develop a personal action plan.

To learn more about Live Better Louisiana, visit www.bcbsla.com/OGB, select your plan and then click the Wellness tab. To sign up for a clinic near you, go to www.timeconfirm.com/ogb or call 1 (877) 841-3058.

*[1]Catapult Health is an independent vendor that provides worksite health screenings for Blue Cross and Blue Shield of Louisiana and its subsidiaries.*

*[2]If you got your premium credit for a prior year, you will need to qualify again for 2021. To complete the checkup, you must be the primary member on a OGB Blue Cross policy that is in effect at the time of the checkup. To get the credit, you must be the primary member on an OGB Blue Cross policy in 2021.*

## My Health, My Way

Get access to My Health, My Way—a full set of health tools at no extra charge to you! This program includes interactive trackers for weight, exercise and food intake, customizable fitness and nutrition plans and online workshops on several health topics. Combine these tools with your Live Better Louisiana resources for a powerful wellness game plan! Log in at www.bcbsla.com/pha today to access your Personal Health Assessment and so much more!

## Health Education

Visit our extensive online health library at www.bcbsla.com/wellness. There you can watch educational and entertaining videos on health topics or check the latest medical guidelines for specific ages and gender. Log in to your personal account at www.bcbsla.com to read Health Condition Guides on common illnesses and injuries and take advantage of multimedia self-care workbooks on asthma, diabetes, COPD, heart disease and heart failure that will help you learn more about living well with these conditions.

## Quit Smoking

Quitting can be easier with free, confidential support. The Louisiana Tobacco Quitline can help! Call 1-800-QUIT-NOW or enroll for free at www.quitwithusla.org. Choose phone counseling, web support or both to develop a quit plan that works for you.

## Discounts for Non-covered Prescription Drugs

OGB members have free access to a prescription coupon program that gives you discounts on some non-covered drugs—that is, medications not covered by your pharmacy benefits. The program is accepted at more than 56,000 pharmacies nationwide. Find out more at www.bcbsla.com/ogb under OGB Customer Forms > "Non-covered Drug Discount Program."

## Blue365®

Through our national association of Blue Cross plans, Blue365® helps you save on a healthier lifestyle with deals on gym memberships, healthy eating options, hearing and vision products, family activities, financial health, travel and more.

Examples include:

- Exclusive $29/month membership to 10,000+ gyms nationwide (with three-month commitment)
- 15% - 35% off of fitness gear, including Reebok, Skechers, heart rate monitors and more
- 10-40% off Davis Vision products
- Discounts of 20-50% to a network of dentists

Go to www.bcbsla.com/ogb to get started.

# Tools

Blue Cross offers a wide range of online tools, social media accounts and a mobile app for those members who like to get their information while on the go. Activate or log in to your account at www.bcbsla.com/ogb to access any of these tools.

## My Account

The Blue Cross website, www.bcbsla.com, offers password-protected tools to review your claims and see a summary of your benefits, as well as access health education, self-care guides, treatment options, OGB's wellness program and discounts and deals.

If you need help registering your online account, call the 24-hour support line at 1 (800) 821-2753.

## Mobile App

Find a doctor, view your claims, find a plan—all on your mobile device, thanks to our mobile-friendly website and our mobile app for both iOS and Android. Download the BCBSLA Mobile App from your App Store or Google Play today!

## Social Hub

If you follow Facebook or Twitter, check out Blue Cross' accounts on those services and several others. At www.bcbsla.com/social, you can access all of our social accounts for wellness tips, recipes, breaking health news and more—as well as a sense of community.

## Dedicated Customer Service Phone Lines Are Open Later

Blue Cross and Blue Shield of Louisiana has a customer service team specifically for OGB members. And now, they are open longer. It can be hard to find a private place and time to talk about your health or health insurance during the day. That's why we opened our phone lines a few extra hours in the evening. Members can call us from **8 a.m. to 8 p.m.**, **Monday through Friday**. OGB members should call 1 (800) 392-4089. We'll be glad to help.

This Annual Enrollment Guide is presented for general information only. It is not a benefit plan, nor intended to be construed as the Blue Cross benefit plan document. If there is any discrepancy between this Annual Enrollment Guide and the Blue Cross benefit plan document and Schedule of Benefits, the FINAL Blue Cross benefit plan document and Schedule of Benefits will govern the benefits and plan payments.

# Pelican HRA1000

# Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** Lifetime Maximum Benefit
- **Benefit Period:** 01/01/20 – 12/31/20

## Deductible per Benefit Period

| | Network | Non-Network |
|---|---|---|
| Individual | $2,000 | $4,000 |
| Family | $4,000 | $8,000 |

***NOTE about your deductible:*** *Deductibles for network and non-network providers are separate. Eligible Expenses for services of a Network Provider that apply to the Deductible Amount for Network Providers* ***will not*** *count toward 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*** *count toward the Deductible Amount for Network Providers.*

## Coinsurance

| | Plan Pays | You Pay |
|---|---|---|
| Network | 80% | 20% |
| Non-Network | 60% | 40% |

### What Is Coinsurance?

This plan includes a cost-sharing arrangement called coinsurance, which means your plan pays the majority of your covered medical expenses, and you pay a small percentage.

## Out-of-Pocket Maximum

| | Network | Non-Network |
|---|---|---|
| Individual | $5,000 | $10,000 |
| Family | $10,000 | $20,000 |

*Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments*

***NOTE about Out-of-Pocket Maximum:*** *There may be a significant Out-of-Pocket expense to the Plan Participant when using a Non-Network Provider.*

Out-of-Pocket Maximums for network and non-network providers are separate. Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Maximum for Network Providers **will not** count toward the Out-of-Pocket Maximum for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Maximum for Non-Network Providers **will not** count toward the Out-of-Pocket Maximum for Network Providers.

When you have satisfied the maximum Out-of-Pocket amounts shown above, this Plan will pay 100% of the Allowable Charge toward Eligible Expenses for the remainder of the Plan Year. The Allowable Charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

**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.

## Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Physician's Office Visits including surgery performed in an office setting:<br>• General Practice<br>• Family Practice<br>• Internal Medicine<br>• OB/GYN<br>• Pediatrics<br>• Geriatrics | 80% - 20%[1] | 60% - 40%[1] |
| Allied Health/Other Office Visits:<br>• Chiropractor<br>• Retail Health Clinic<br>• Nurse Practitioner<br>• Physician's Assistant | 80% - 20%[1] | 60% - 40%[1] |
| Specialist Office Visits including surgery performed in an office setting:<br>• Physician<br>• Podiatrist<br>• Optometrist<br>• Midwife<br>• Audiologist<br>• Registered Dietician<br>• Sleep Disorder Clinic | 80% - 20%[1] | 60% - 40%[1] |
| Ambulance Services - Ground | 80% - 20%[1] | 80% - 20%[1] |
| Ambulance Services - Air (Non-emergency requires prior authorization[2]) | 80% - 20%[1] | 80% - 20%[1] |
| Ambulatory Surgical Center and Outpatient Surgical Facility | 80% - 20%[1] | 60%-40%[1] |
| Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan) | 100% - 0% | 60% - 40%[1] |
| Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year) | 80% - 20%[1,2,3] | 60% - 40%[1,2,3] |
| Chemotherapy/Radiation Therapy | 80% - 20%[1] | 60% - 40%[1] |
| Diabetes Treatment | 80% - 20%[1] | 60% - 40%[1] |

[1]Subject to Plan Year Deductible | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary | [3]Age and/or time restrictions apply

## Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Diabetic/Nutritional Counseling | 80% - 20%[1] | Not covered |
| Dialysis | 80% - 20%[1] | 60% - 40%[1] |
| Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Emergency Room (facility charge) | 80% - 20%[1] | 80% - 20%[1] |
| Emergency Medical Services (non-facility charge) | 80% - 20%[1] | 80% - 20%[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] | Not covered |
| Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair) | 100% - 0% | 100% - 0% |
| Hearing Aids (not covered for individuals age 18 and older) | 80% - 20%[1,3] | Not covered |
| High-Tech Imaging – Outpatient (CT Scans, MRI/MRA, nuclear cardiology, PET scans) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Home Health Care (limit of 60 visits per Plan Year) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Hospice Care (limit of 180 days per Plan Year) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Injections Received in a Physician's Office (when no other health services are received) | 80% - 20%[1] | 60% - 40%[1] |
| Inpatient Hospital Admission (all Inpatient Hospital services included) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Inpatient and Outpatient Professional Services | 80% - 20%[1] | 60% - 40%[1] |
| Mastectomy Bras (limited to three per Plan Year) | 80% - 20%[1] | 60% - 40%[1] |
| Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient programs | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs) | 80% - 20%[1] | 60% - 40%[1] |

[1]Subject to Plan Year Deductible | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary | [3]Age and/or time restrictions apply

## Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Newborn – Sick, services excluding facility | 80% - 20%[1] | 60% - 40%[1] |
| Newborn – Sick, facility | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Oral Surgery | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Pregnancy Care – Physician Services | 80% - 20%[1] | 60% - 40%[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/Routine Care article in the Benefit Plan.) | 100% - 0%[3] | 100% - 0%[3] |
| Rehabilitation Services – Outpatient:<br>• Speech<br>• Physical/Occupational[2] (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.)<br>• Pulmonary Therapies (limit 30 visits per Plan Year)<br>Visit limits do not apply when services are provided for Autism Spectrum Disorders. | 80% - 20%[1] | 60% - 40%[1] |
| Skilled Nursing Facility (limit of 90 days per Plan Year) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Sonograms and Ultrasounds – Outpatient | 80% - 20%[1] | 60% - 40%[1] |
| Transplants – Organ, Tissue and Bone Marrow | 80% - 20%[1,2] | Not Covered |
| Urgent Care Center | 80% - 20%[1] | 60% - 40%[1] |
| Vision Care (Non-Routine) Exam | 80% - 20%[1] | 60% - 40%[1] |
| X-Ray and Laboratory Services (low-tech imaging) | 80% - 20%[1] | 60% - 40%[1] |

[1]Subject to Plan Year Deductible | [2]Pre-authorization required, if applicable. Not applicable for Medicare primary | [3]Age and/or time restrictions apply

# Your Prescription Drug Coverage

**MedImpact Formulary: 4-Tier Plan Design**

OGB uses the MedImpact Formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed quarterly to reassess drug tiers based on the current prescription drug market. You will continue to pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

| Tier | Your Responsibility |
|---|---|
| Generic | 50% coinsurance up to $30 |
| Preferred Brand | 50% coinsurance up to $55 |
| Non-Preferred Brand | 65% coinsurance up to $80 |
| Specialty | 50% coinsurance up to $80 |
| **Once you and/or your covered dependent(s) reach $1,500 out of-pocket threshold, the following copayments apply:** | |
| Generic | $ 0 copayment |
| Preferred Brand | $20 copayment |
| Non-Preferred Brand | $40 copayment |
| Specialty | $40 copayment |

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

## 90-Day Fill Option

For maintenance medications, 90-day prescriptions may be filled for the applicable coinsurance amount, with a maximum that is two and a half times the maximum copayment.

## What is a Health Reimbursement Arrangement (HRA)?

The Pelican HRA1000 is a consumer-driven health plan with a Health Reimbursement Arrangement (HRA). This plan has low premiums and an employer-funded HRA, which reimburses you for qualified medical expenses.

Your employer contributes to the Pelican HRA1000 $1,000 annually for employee-only plans and $2,000 annually for family plans. The HRA pays for 100% of covered medical expenses from any healthcare provider until the fund is used up. The HRA also counts toward your total deductible for the year. HRA funds you do not spend will roll over each year up to the in-network out-of-pocket maximum as long as you remain enrolled in the Pelican HRA1000 Plan.

### HRA vs. HSA (Health Savings Account): What's the difference?

| | Health Reimbursement Arrangement (HRA) | Health Savings Account (HSA) |
|---|---|---|
| Funding | • Employer funds HRA. Only employers may contribute.<br>• Funds stay with the employer if employee leaves an OGB-participating employer.<br>• Contributions are not taxable. | • Both employer and employee may fund HSA.<br>• Funds go with the employee if he/she leaves an OGB-participating employer.<br>• Contributions are made on a pre-tax basis. |
| Flexibility | • Employer selects maximum contribution.<br>• Must be paired with the Pelican HRA1000.<br>• Contributions are the same for each employee.<br>• May be used with a General-Purpose FSA. | • IRS determines maximum contribution.<br>• Must be paired with the Pelican HSA775.<br>• Contributions are determined by employee and employer.<br>• May be used only with a Limited-Purpose FSA. |
| Simplicity | • HRA claims are processed by the claims administrator. | • Employee manages account and submits expenses to the HSA trustee for reimbursement. |

# Pelican HSA775

# Schedule of Benefits

Active employees
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** Lifetime Maximum Benefit
- **Benefit Period:** 01/01/20 – 12/31/20

## Deductible per Benefit Period

| | Network | Non-Network |
|---|---|---|
| Individual | $2,000 | $4,000 |
| Family | $4,000 | $8,000 |

***NOTE about your deductible:*** *Deductibles for network and non-network providers are separate. Eligible Expenses for services of a Network Provider that apply to the Deductible Amount for Network Providers* ***will not*** *count toward 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*** *count toward the Deductible Amount for Network Providers.*

## Coinsurance

| | Plan Pays | You Pay |
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| Network | 80% | 20% |
| Non-Network | 60% | 40% |

### What Is Coinsurance?

This plan includes a cost-sharing arrangement called coinsurance, which means your plan pays the majority of your covered medical expenses, and you pay a small percentage.

## Out-of-Pocket Maximum

| | Network | Non-Network |
|---|---|---|
| Individual | $5,000 | $10,000 |
| Family | $10,000 | $20,000 |

*Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments*

***NOTE about Out-of-Pocket Maximum:*** *There may be a significant Out-of-Pocket expense to the Plan Participant when using a Non-Network Provider.*

Out-of-Pocket Maximums for network and non-network providers are separate. Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Maximum for Network Providers **will not** count toward the Out-of-Pocket Maximum for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Maximum for Non-Network Providers **will not** count toward the Out-of-Pocket Maximum for Network Providers.

When you have satisfied the maximum Out-of-Pocket amounts shown above, this Plan will pay 100% of the Allowable Charge toward Eligible Expenses for the remainder of the Plan Year. The Allowable Charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

**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.

## Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Physician's Office Visits including surgery performed in an office setting:<br>• General Practice<br>• Family Practice<br>• Internal Medicine<br>• OB/GYN<br>• Pediatrics<br>• Geriatrics | 80% - 20%[1] | 60% - 40%[1] |
| Allied Health/Other Office Visits:<br>• Chiropractor<br>• Retail Health Clinic<br>• Nurse Practitioner<br>• Physician's Assistant | 80% - 20%[1] | 60% - 40%[1] |
| Specialist Office Visits including surgery performed in an office setting:<br>• Physician<br>• Podiatrist<br>• Optometrist<br>• Midwife<br>• Audiologist<br>• Registered Dietician<br>• Sleep Disorder Clinic | 80% - 20%[1] | 60% - 40%[1] |
| Ambulance Services - Ground | 80% - 20%[1] | 80% - 20%[1] |
| Ambulance Services - Air (Non-emergency requires prior authorization[2]) | 80% - 20%[1] | 80% - 20%[1] |
| Ambulatory Surgical Center and Outpatient Surgical Facility | 80% - 20%[1] | 60% - 40%[1] |
| Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness article in the Benefit Plan) | 100% - 0% | 60% - 40%[1] |
| Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year) | 80% - 20%[1,2,3] | 60% - 40%[1,2,3] |
| Chemotherapy/Radiation Therapy | 80% - 20%[1] | 60% - 40%[1] |
| Diabetes Treatment | 80% - 20%[1] | 60% - 40%[1] |

[1]Subject to Plan Year Deductible | [2]Pre-authorization required | [3]Age and/or time restrictions apply

## Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Diabetic/Nutritional Counseling | 80% - 20%[1] | Not covered |
| Dialysis | 80% - 20%[1] | 60% - 40%[1] |
| Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Emergency Room (facility charge) | 80% - 20%[1] | 80% - 20%[1] |
| Emergency Medical Services (non-facility charge) | 80% - 20%[1] | 80% - 20%[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] | Not covered |
| Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, pharmacy, job site or health fair) | 100% - 0% | 100% - 0% |
| Hearing Aids (not covered for individuals age 18 and older) | 80% - 20%[1,3] | Not covered |
| High-Tech Imaging – Outpatient (CT Scans, MRI/MRA, nuclear cardiology, PET scans) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Home Health Care (limit of 60 visits per Plan Year) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Hospice Care (limit of 180 days per Plan Year) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Injections Received in a Physician's Office (when no other health services are received) | 80% - 20%[1] | 60% - 40%[1] |
| Inpatient Hospital Admission (all Inpatient Hospital services included) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Inpatient and Outpatient Professional Services | 80% - 20%[1] | 60% - 40%[1] |
| Mastectomy Bras (limited to three per Plan Year) | 80% - 20%[1] | 60% - 40%[1] |
| Mental Health/Substance Use Disorder – Inpatient treatment and intensive outpatient treatment | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs) | 80% - 20%[1] | 60% - 40%[1] |

[1]Subject to Plan Year Deductible | [2]Pre-authorization required | [3]Age and/or time restrictions apply

## Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Newborn – Sick, services excluding facility | 80% - 20%[1] | 60% - 40%[1] |
| Newborn – Sick, facility | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Oral Surgery | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Pregnancy Care – Physician Services | 80% - 20%[1] | 60% - 40%[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/Routine Care article in the Benefit Plan.) | 100% - 0%[3] | 100% - 0%[3] |
| Rehabilitation Services – Outpatient:<br>• Speech<br>• Physical/Occupational[2] (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.)<br>• Pulmonary Therapies (limit 30 visits per Plan Year)<br>Visit limits do not apply when services are provided for Autism Spectrum Disorders. | 80% - 20%[1] | 60% - 40%[1] |
| Skilled Nursing Facility (limit of 90 days per Plan Year) | 80% - 20%[1,2] | 60% - 40%[1,2] |
| Sonograms and Ultrasounds – Outpatient | 80% - 20%[1] | 60% - 40%[1] |
| Transplants – Organ, Tissue and Bone Marrow | 80% - 20%[1,2] | Not Covered |
| Urgent Care Center | 80% - 20%[1] | 60% - 40%[1] |
| Vision Care (Non-Routine) Exam | 80% - 20%[1] | 60% - 40%[1] |
| X-Ray and Laboratory Services (low-tech imaging) | 80% - 20%[1] | 60% - 40%[1] |

[1]Subject to Plan Year Deductible | [2]Pre-authorization required | [3]Age and/or time restrictions apply

# Your Prescription Drug Program

**Administered by Express Scripts, Inc. (ESI) | Member Drug Questions - (866) 781-7533**

Blue Cross and Blue Shield of Louisiana works with Express Scripts, Inc. (ESI) to administer our prescription drug program. For ESI's list of generic, preferred brand, non-preferred brand, specialty and maintenance/preventive drugs, go to www.bcbsla.com/ogb.

ESI has a robust pharmacy network that consists of a large group of conveniently located participating retail pharmacies as well as an optional mail-service program. You may use any pharmacy you wish, but there are advantages to selecting a participating network pharmacy:

- Lower costs
- No claims to file
- No waiting for reimbursement

| Tier | Your Responsibility |
|---|---|
| Generic (up to 93-day supply/three copayments) | $10 copayment per 31-day supply |
| Preferred Brand (up to 93-day supply/ three copayments) | $25 copayment per 31-day supply |
| Non-Preferred Brand (up to 93-day supply/three copayments) | $50 copayment per 31-day supply |
| Specialty (up to 31-day supply/ one copayment) | $50 copayment per 31-day supply |

- **Retail and Mail Order** - Subject to deductible
- **Select Maintenance Drugs** - Not subject to deductible; subject to applicable copayments above up to a 93-day supply.

## What Is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a savings account you can use with Pelican HSA775, a consumer-driven health plan. The HSA allows you to save money tax-free for medical and pharmacy expenses. It can help you meet your deductible, pay any applicable copayments and help you save for future healthcare expenses.

If you choose the HSA option, the state will contribute $200 at the start of the plan year to help jump-start your savings. The state will then match the tax-free contributions you make through payroll deductions up to an additional $575 per plan year. The state may contribute a total of $775 per plan year, but you can contribute beyond that; for the 2020 calendar year, the U.S. Internal Revenue Service (IRS) limits total tax-free HSA contributions to $3,550* for employee only coverage and $7,100 for family coverage—plus an additional $1,000 if you are age 55 or older.

Because you own the HSA, you decide when and how to spend the money. You can use the tax-free dollars in your HSA to pay eligible medical and pharmacy expenses now, or you can pay these expenses out-of-pocket and let your HSA grow. Your money can remain in your HSA and earn tax-free interest from year to year.

**If you wish to apply for an HSA, you should enroll through the online annual enrollment portal or through your human resources office. You SHOULD NOT submit applications directly to Health Equity.****

If you change health plans or jobs, or if you retire, the HSA is yours to keep. From age 65 on, you can use your HSA dollars for any healthcare or non-healthcare expense with no penalty, although any amount used for non-healthcare expenses will be taxable as income.

**These amounts were announced by the IRS for 2020. They may change annually and are subject to additional IRS rules. Check with your tax advisor. Information can also be found at www.irs.gov.*

***Health Equity, which owns MySmart$aver, is an independent company that provides HSA options to customers of Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.*

# Magnolia Local Plus

# Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** Lifetime Maximum Benefit
- **Benefit Period:** 01/01/20 – 12/31/20

## Deductible per Benefit Period

**Active Employees and Retirees** (retirement date ON or AFTER 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $400 | No coverage |
| Individual + 1 Dependent | $800 | No coverage |
| Family (Individual + 2 or more Dependents) | $1,200 | No coverage |

**Retirees** (retirement date PRIOR to 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $0 | No coverage |
| Individual + 1 Dependent | $0 | No coverage |
| Family (Individual + 2 or more Dependents) | $0 | No coverage |

## Out-of-Pocket Maximum

**Active Employees and Retirees** (retirement date ON or AFTER 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $3,500 | No coverage |
| Individual + 1 Dependent | $6,000 | No coverage |
| Family (Individual + 2 or more Dependents) | $8,500 | No coverage |

*Includes all eligible Copayments, Coinsurance Amounts and Deductibles*

**Retirees** (retirement date PRIOR to 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $2,000 | No coverage |
| Individual + 1 Dependent | $3,000 | No coverage |
| Family (Individual + 2 or more Dependents) | $4,000 | No coverage |

*Includes all eligible Copayments, Coinsurance Amounts and Deductibles*

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** are reimbursed in accordance with a fee schedule of maximum Allowable Charges, not billed charges. An allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

## Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Physician's Office Visits including surgery performed in an office setting:<br>• General Practice<br>• Family Practice<br>• Internal Medicine<br>• OB/GYN<br>• Pediatrics<br>• Geriatrics | $25 Copayment per Visit | No Coverage |
| Allied Health/Other Office Visits:<br>• Chiropractor<br>• Federally Funded Qualified Rural Health Clinic<br>• Nurse Practitioner<br>• Retail Health Clinic<br>• Physician's Assistant | $25 Copayment per Visit | No Coverage |
| Specialist Office Visits including surgery performed in an office setting:<br>• Physician<br>• Podiatrist<br>• Optometrist<br>• Midwife<br>• Audiologist<br>• Registered Dietician<br>• Sleep Disorder Clinic | $50 Copayment per Visit | No Coverage |
| Ambulance Services - Ground | $50 Copayment | $50 Copayment (Emergency Medical Transportation Only) |
| Ambulance Services - Air (Non-emergency requires prior authorization[2]) | $250 Copayment | No Coverage |
| Ambulatory Surgical Center and Outpatient Surgical Facility | $100 Copayment | 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/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year) | $25/$50 Copayment per day depending on Provider type[2,3]<br>$50 Copayment – Outpatient Facility[2,3] | No Coverage |
| Chemotherapy/Radiation Therapy | Office – $25 Copayment per Visit<br>Outpatient Facility 100% - 0%[1] | No Coverage |
| Diabetes Treatment | 80% - 20%[1] | No Coverage |
| Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities | $25 Copayment | No Coverage |
| Dialysis | 100% - 0%[1] | 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) | $200 Copayment; Waived if Admitted to the Same Facility | |
| Emergency Medical Services (non-facility charge) | 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 (not covered for individuals age 18 and older) | 80% - 20%[1,3] | 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/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| High-Tech Imaging – Outpatient<br>• CT Scans<br>• MRA/MRI<br>• Nuclear Cardiology<br>• PET Scans | $50 Copayment[2] | No Coverage |
| 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) | $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 (limited to three per Plan Year) | 80% - 20%[1] 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 Use Disorder – Inpatient treatment and intensive outpatient programs | $100 Copayment per day[2], maximum of $300 per Admission | No Coverage |
| Mental Health/Substance Use Disorder – Office visits and outpatient treatment other than intensive outpatient programs | $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 | 100% - 0%[1,2] | 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/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| 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/Routine Care article in the Benefit Plan.) | 100% - 0%[3] | No Coverage |
| Rehabilitation Services – Outpatient:<br>• Physical/Occupational (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.)<br>• Speech<br>• Cognitive<br>• Hearing Therapy<br>Visit limits do not apply when services are provided for Autism Spectrum Disorders | $25 Copayment per Visit | No Coverage |
| Skilled Nursing Facility (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 |
| Transplants – Organ, Tissue and Bone Marrow | 100% - 0%[1,2] after deductible | No Coverage |
| Urgent Care Center | $50 Copayment | No Coverage |
| Vision Care (Non-Routine) Exam | $25/$50 Copayment depending on Provider type | No Coverage |
| X-Ray and Laboratory Services (low-tech imaging) | Office or Independent Lab 100% - 0%<br>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

# Your Prescription Drug Coverage

**MedImpact Formulary: 4-Tier Plan Design**

OGB uses the MedImpact Formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed quarterly to reassess drug tiers based on the current prescription drug market. You will continue to pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

| Tier | Your Responsibility |
|---|---|
| Generic | 50% coinsurance up to $30 |
| Preferred Brand | 50% coinsurance up to $55 |
| Non-Preferred Brand | 65% coinsurance up to $80 |
| Specialty | 50% coinsurance up to $80 |
| **Once you and/or your covered dependent(s) reach $1,500 out of-pocket threshold, the following copayments apply:** | |
| Generic | $ 0 copayment |
| Preferred Brand | $20 copayment |
| Non-Preferred Brand | $40 copayment |
| Specialty | $40 copayment |

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

## 90-Day Fill Option

For maintenance medications, 90-day prescriptions may be filled for the applicable coinsurance amount with a maximum that is two and a half times the maximum copayment.

# Magnolia Open Access

# Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare
Nationwide Network Coverage | Preferred Care Providers and BCBS National Providers

- **Unlimited** Lifetime Maximum Benefit
- **Benefit Period:** 01/01/20 – 12/31/20
- **Eligibility:** The Plan Administrator assigns Eligibility to all Plan Participants.

## Deductible per Benefit Period

**Active Employees and Retirees** (retirement date ON or AFTER 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $900 | $900 |
| Individual + 1 Dependent | $1,800 | $1,800 |
| Family (Individual + 2 or more Dependents) | $2,700 | $2,700 |

**Retirees** (retirement date PRIOR to 03/01/15) (with and without Medicare)

| | Network and Non-Network |
|---|---|
| Individual | $300 |
| Individual + 1 Dependent | $600 |
| Family (Individual + 2 or more Dependents) | $900 |

***NOTE about your deductible for Active and Retirees on or after 03/01/15:*** *Deductibles for network and non-network providers are separate. Eligible Expenses for services of a Network Provider that apply to the Deductible Amount for Network Providers* ***will not*** *count toward 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*** *count toward the Deductible Amount for Network Providers.*

***NOTE about your deductible for Retirees Prior to 03/01/15:*** *The Deductible Amount is a single amount that includes eligible charges incurred from all Providers combined.*

## Out-of-Pocket Maximum

**Active Employees and Retirees** (retirement date ON or AFTER 03/01/15)

| | Network | Non-Network |
|---|---|---|
| Individual | $3,500 | $4,700 |
| Individual + 1 Dependent | $6,000 | $8,500 |
| Individual + 2 Dependents | $8,500 | $12,250 |
| Individual + 3 Dependents | $8,500 | $12,250 |
| Individual + 4 Dependents | $8,500 | $12,250 |
| Individual + 5 Dependents | $8,500 | $12,250 |
| Individual + 6 Dependents | $8,500 | $12,250 |
| Individual + 7 Dependents | $8,500 | $12,250 |
| Individual + 8 Dependents | $8,500 | $12,250 |
| Individual + 9 Dependents | $8,500 | $12,250 |
| Individual + 10 Dependents | $8,500 | $12,250 |
| Individual + 11 or more Dependents | $8,500 | $12,250 |

*Includes all eligible Copayments, Coinsurance Amounts and Deductibles*

***NOTES about Out-of-Pocket Maximum for Active and Retirees on or after 03/01/15:*** *There may be a significant Out-of-Pocket expense to the Plan Participant when services are received from a Non-Network Provider.*

**Active Employees and Retirees (retirement date ON or AFTER 03/01/15):**
Out-of-Pocket Maximums for network and non-network providers are separate. Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Maximum for Network Providers ***will not*** count toward the Out-of-Pocket Maximum for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Maximum for Non-Network Providers ***will not*** count toward the Out-of-Pocket Maximum for Network Providers.

## Out-of-Pocket Maximum

**Retirees without Medicare** (retirement date PRIOR to 03/01/15)

| | Network | Non-Network |
|---|---|---|
| Individual | $2,300 | $4,300 |
| Individual + 1 Dependent | $3,600 | $7,600 |
| Individual + 2 Dependents | $4,900 | $10,900 |
| Individual + 3 Dependents | $5,900 | $13,700 |
| Individual + 4 Dependents | $6,900 | $13,700 |
| Individual + 5 Dependents | $7,900 | $13,700 |
| Individual + 6 Dependents | $8,900 | $13,700 |
| Individual + 7 Dependents | $9,900 | $13,700 |
| Individual + 8 Dependents | $10,900 | $13,700 |
| Individual + 9 Dependents | $11,900 | $13,700 |
| Individual + 10 Dependents | $12,900 | $13,700 |
| Individual + 11 or more Dependents | $13,700 | $13,700 |

*Includes all eligible Copayments, Coinsurance Amounts and Deductibles*

**Retirees (retirement date PRIOR to 03/01/15) without Medicare:**
Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Maximum for Network Providers will count toward the Out-of-Pocket Maximum for Non-Network Providers.

Eligible Expenses for services of Non-Network Providers that apply to the Out-of-Pocket Maximum for Non-Network Providers will count toward the Out-of-Pocket Maximum for Network Providers.

## Out-of-Pocket Maximum

**Retirees with Medicare** (retirement date PRIOR to 03/01/15)

| | Network and Non-Network |
|---|---|
| Individual | $3,300 |
| Individual + 1 Dependent | $5,600 |
| Individual + 2 Dependents | $7,900 |
| Individual + 3 Dependents | $9,900 |
| Individual + 4 Dependents | $11,900 |
| Individual + 5 Dependents | $13,700 |
| Individual + 6 Dependents | $13,700 |
| Individual + 7 Dependents | $13,700 |
| Individual + 8 Dependents | $13,700 |
| Individual + 9 Dependents | $13,700 |
| Individual + 10 Dependents | $13,700 |
| Individual + 11 or more Dependents | $13,700 |

*Includes all eligible Copayments, Coinsurance Amounts and Deductibles*

**Retirees (retirement date PRIOR to 03/01/15) with Medicare:**
The Out-of-Pocket Amount is a single amount that includes eligible charges incurred from all Providers combined. When the Out-of-Pocket Maximums, 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.

**All members:**
When the Out-of-Pocket Maximums, 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. The Allowable Charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

**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.

## Coinsurance

First number is the percentage your plan pays; second number is the percentage you pay

| | Active Employees/ Non-Medicare Retirees | | Retirees with Medicare |
|---|---|---|---|
| | Network Providers | Non-Network Providers | Network and Non-Network Providers |
| Physician's Office Visits including surgery performed in an office setting:<br>• General Practice<br>• Family Practice<br>• Internal Medicine<br>• OB/GYN<br>• Pediatrics<br>• Geriatrics | 90% - 10%[1] | 70% - 30%[1] | 80% - 20%[1] |
| Allied Health/Other Office Visits:<br>• Chiropractor<br>• Nurse Practitioner<br>• Osteopath<br>• Physician's Assistant<br>• Retail Health Clinic | 90% - 10%[1] | 70% - 30%[1] | 80% - 20%[1] |
| Specialist (Physician) Office Visits including surgery performed in an office setting:<br>• Physician<br>• Podiatrist<br>• Midwife<br>• Audiologist<br>• Registered Dietician<br>• Sleep Disorder Clinic<br>• Optometrist | 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 Article in the Benefit Plan) | 100% - 0% | 70% - 30%[1] | Network Providers 100% - 0%<br>Non-Network Providers 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

First number is the percentage your plan pays; second number is the percentage you pay

| | Active Employees/ Non-Medicare Retirees | | Retirees with Medicare |
|---|---|---|---|
| | Network Providers | Non-Network Providers | Network and Non-Network Providers |
| Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 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] |
| 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 Copayment; Waived if Admitted to the Same Facility | | |
| | 90% - 10%[1] | 90% - 10%[1] | 80% - 20%[1] |
| Emergency Medical Services (non-facility charge) | 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 months following cataract surgery) | Eyeglass Frames - Limited to a Maximum Benefit of $50[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 (not covered for individuals age 18 and older) | 90% - 10%[1,3] | 70% - 30%[1,3] | 80% - 20%[1,3] |
| High-Tech Imaging – Outpatient<br>• CT Scans<br>• MRA/MRI<br>• Nuclear Cardiology<br>• PET Scans | 90% - 10%[1,2] | 70% - 30%[1,2] | 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

First number is the percentage your plan pays; second number is the percentage you pay

| | Active Employees/ Non-Medicare Retirees | | Retirees with Medicare |
|---|---|---|---|
| | Network Providers | Non-Network Providers | Network and Non-Network Providers |
| 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<br>Day maximum: Not Applicable<br>Coinsurance: 90% - 10%[1,2] | Per day copayment: $50<br>Day maximum: 5 Days<br>Coinsurance: 70% - 30%[1,2] | Per day copayment: $0<br>Day maximum: Not Applicable<br>Coinsurance: 80% - 20%[1] |
| Inpatient and Outpatient Professional Services | 90% - 10%[1] | 70% - 30%[1] | 80% - 20%[1] |
| Mastectomy Bras (limited to three per Plan Year) | 90% - 10%[1] | 70% - 30%[1] | 80% - 20%[1] |
| Mental Health/Substance Use Disorder - Inpatient treatment and intensive outpatient treatment | Per day copayment: $0<br>Day maximum: Not Applicable<br>Coinsurance: 90% - 10%[1,2] | Per day copayment: $50<br>Day maximum: 5 Days<br>Coinsurance: 70% - 30%[1,2] | Per day copayment: $0<br>Day maximum: Not Applicable<br>Coinsurance: 80% - 20%[1] |
| Mental Health/Substance Use Disorder – Office 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<br>Day maximum: Not Applicable<br>Coinsurance: 90% - 10%[1,2] | Per day copayment: $50<br>Day maximum: 5 Days<br>Coinsurance: 70% - 30%[1,2] | Per day copayment: $0<br>Day maximum: Not Applicable<br>Coinsurance: 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

First number is the percentage your plan pays; second number is the percentage you pay

| | Active Employees/ Non-Medicare Retirees | | Retirees with Medicare |
|---|---|---|---|
| | Network Providers | Non-Network Providers | Network and Non-Network Providers |
| 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/Routine Care Article in the Benefit Plan.) | 100% - 0%[3] | 70% - 30%[1,3] | Network Providers 100% - 0%[3] Non-Network Providers 80% - 20%[1,3] |
| Rehabilitation Services – Outpatient:<br>• Physical/Occupational (limit of 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.)<br>• Speech<br>(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] |
| Transplants - Organ, Tissue and Bone Marrow | 90% - 10%[1,2] | 70% - 30%[1,2] | 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 and Laboratory Services (low-tech imaging) | 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

# Your Prescription Drug Coverage

**MedImpact Formulary: 4-Tier Plan Design**

OGB uses the MedImpact Formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed quarterly to reassess drug tiers based on the current prescription drug market. You will continue to pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you receive a generic, specialty, preferred brand or non-preferred brand-name drug.

| Tier | Your Responsibility |
|---|---|
| Generic | 50% coinsurance up to $30 |
| Preferred Brand | 50% coinsurance up to $55 |
| Non-Preferred Brand | 65% coinsurance up to $80 |
| Specialty | 50% coinsurance up to $80 |
| **Once you and/or your covered dependent(s) reach $1,500 out of-pocket threshold, the following copayments apply:** | |
| Generic | $ 0 copayment |
| Preferred Brand | $20 copayment |
| Non-Preferred Brand | $40 copayment |
| Specialty | $40 copayment |

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

## 90-Day Fill Option

For maintenance medications, 90-day prescriptions may be filled for the applicable coinsurance amount with a maximum that is two and a half times the maximum copayment.

# Magnolia Local

# Schedule of Benefits

Active employees, Retirees without Medicare, Retirees with Medicare

- **Unlimited** Lifetime Maximum Benefit
- **Benefit Period:** 01/01/20 – 12/31/20

### About the Network

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

This plan is a limited provider in-network only plan for members who live in specific coverage areas. Out-of-network care is provided only in emergencies.

## Community Blue

A select, local network designed for members who live in the parishes of:

- Ascension
- East Baton Rouge
- Livingston
- West Baton Rouge

## Blue Connect

A select, local network designed for members who live in the parishes of:

- Acadia
- Bossier
- Caddo
- Evangeline
- Iberia
- Jefferson
- Lafayette
- Orleans
- Plaquemines
- St. Bernard
- St. Charles
- St. John the Baptist
- St. Landry
- St. Martin
- St. Mary
- St. Tammany
- Vermilion

## Deductible per Benefit Period

**Active Employees and Retirees** (retirement date ON or AFTER 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $400 | No coverage |
| Individual + 1 Dependent | $800 | No coverage |
| Family (Individual + 2 or more Dependents) | $1,200 | No coverage |

**Retirees** (retirement date PRIOR to 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $0 | No coverage |
| Individual + 1 Dependent | $0 | No coverage |
| Family (Individual + 2 or more Dependents) | $0 | No coverage |

## Out-of-Pocket Maximum

**Active Employees and Retirees** (retirement date ON or AFTER 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $2,500 | No coverage |
| Individual + 1 Dependent | $5,000 | No coverage |
| Family (Individual + 2 or more Dependents) | $7,500 | No coverage |

*Includes all eligible Copayments, Coinsurance Amounts and Deductibles*

**Retirees** (retirement date PRIOR to 03/01/15) (with and without Medicare)

| | Network | Non-Network |
|---|---|---|
| Individual | $1,000 | No coverage |
| Individual + 1 Dependent | $2,000 | No coverage |
| Family (Individual + 2 or more Dependents) | $3,000 | No coverage |

*Includes all eligible Copayments, Coinsurance Amounts and Deductibles*

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** are reimbursed in accordance with a fee schedule of maximum Allowable Charges, not billed charges. An allowable charge is the amount we decide or agree with providers as the most we will pay for services that are covered by your benefit plan, or the amount a provider charges you, whichever is less.

## Copayments and/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Physician's Office Visits including surgery performed in an office setting:<br>• General Practice<br>• Family Practice<br>• Internal Medicine<br>• OB/GYN<br>• Pediatrics<br>• Geriatrics | $25 Copayment per Visit | No Coverage |
| Allied Health/Other Office Visits:<br>• Chiropractor<br>• Federally Funded Qualified Rural Health Clinic<br>• Nurse Practitioner<br>• Retail Health Clinic<br>• Physician's Assistant | $25 Copayment per Visit | No Coverage |
| Specialist Office Visits including surgery performed in an office setting:<br>• Physician<br>• Podiatrist<br>• Optometrist<br>• Midwife<br>• Audiologist<br>• Registered Dietician<br>• Sleep Disorder Clinic | $50 Copayment per Visit | No Coverage |
| Ambulance Services - Ground | $50 Copayment | $50 Copayment |
| Ambulance Services - Air (Non-emergency requires prior authorization[2]) | $250 Copayment | No Coverage |
| Ambulatory Surgical Center and Outpatient Surgical Facility | $100 Copayment | 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/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| Cardiac Rehabilitation (must begin within six months of qualifying event; limit of 36 visits per Plan Year) | $25/$50 Copayment per day depending on Provider type[2,3]<br>$50 Copayment – Outpatient Facility[2,3] | No Coverage |
| Chemotherapy/Radiation Therapy | Office – $25 Copayment per Visit<br>Outpatient Facility 100% - 0%[1] | No Coverage |
| Diabetes Treatment | 80% - 20%[1] | No Coverage |
| Diabetic/Nutritional Counseling | $25 Copayment | No Coverage |
| Dialysis | 100% - 0%[1] | 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 to the Same Facility | |
| Emergency Medical Services (non-facility charge) | 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 (not covered for individuals age 18 and older) | 80% - 20%[1,3] | 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/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| High-Tech Imaging – Outpatient<br>• CT Scans<br>• MRA/MRI<br>• Nuclear Cardiology<br>• PET Scans | $50 Copayment[2] | No Coverage |
| 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 service is received) | 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 (limited to three per Plan Year) | 80% - 20%[1] 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 Use Disorder – Inpatient treatment and intensive outpatient programs | $100 Copayment per day[2], maximum of $300 per Admission | No Coverage |
| Mental Health/Substance Use Disorder – Office visits and outpatient treatment (other than intensive outpatient programs) | $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 | 100% - 0%[1,2] | 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/or Coinsurance

Copayment is a fixed cost. Coinsurance is indicated with two numbers; the first number is the percentage your plan pays; second number is the percentage you pay

| | Network Providers | Non-Network Providers |
|---|---|---|
| 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/Routine Care article in the Benefit Plan.) | 100% - 0%[3] | No Coverage |
| Rehabilitation Services – Outpatient:<br>• Physical/Occupational (limit of 50 visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.)<br>• Speech<br>• Cognitive<br>• Hearing Therapy<br>Visit limits do not apply when services are provided for Autism Spectrum Disorders | $25 Copayment per Visit | No Coverage |
| Skilled Nursing Facility (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 |
| Transplants – Organ, Tissue and Bone Marrow | 100% - 0%[1,2] after deductible | No Coverage |
| Urgent Care Center | $50 Copayment | No Coverage |
| Vision Care (Non-Routine) Exam | $25/$50 Copayment depending on Provider type | No Coverage |
| X-Ray and Laboratory Services (low-tech imaging) | Office or Independent Lab 100% - 0%<br>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

# Your Prescription Drug Coverage

**MedImpact Formulary: 4-Tier Plan Design**

OGB uses the MedImpact Formulary to help members select the most appropriate, lowest-cost medication options. The formulary is reviewed quarterly to reassess drug tiers based on the current prescription drug market. You will continue to pay a portion of the cost of your prescriptions in the form of a fixed amount (copayment) or a percentage of the cost (coinsurance). The amount you pay toward your prescription depends on whether you choose a generic, specialty, preferred brand or non-preferred brand-name drug.

| Tier | Your Responsibility |
|---|---|
| Generic | 50% coinsurance up to $30 |
| Preferred Brand | 50% coinsurance up to $55 |
| Non-Preferred Brand | 65% coinsurance up to $80 |
| Specialty | 50% coinsurance up to $80 |
| **Once you and/or your covered dependent(s) reach $1,500 out of-pocket threshold, the following copayments apply:** | |
| Generic | $ 0 copayment |
| Preferred Brand | $20 copayment |
| Non-Preferred Brand | $40 copayment |
| Specialty | $40 copayment |

More than one drug may be available to treat your condition. We encourage you to talk with your doctor regularly about which drugs meet your needs at the lowest cost to you.

## 90-Day Fill Option

For maintenance medications, 90-day prescriptions may be filled for the applicable coinsurance amount, with a maximum that is two and a half times the maximum copayment.

# Receive Care in the Best Setting

## General and Specialist Care

If you need routine care, call your doctor and plan an office visit.

## BlueCare

Visit a doctor online from work, home or out of town, without an appointment, with BlueCare. Go to www.bcbsla.com/bluecare to learn more.

## Urgent Care

If you cannot reach your doctor, urgent care or after-hours clinics are great alternatives to the emergency room when you do not have a true emergency.

## Emergency Care

Call 911 or go to the nearest emergency room. An emergency, as defined by state law, is a medical condition of recent onset and severity (including severe pain) that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual, or with respect to a pregnant woman the health of the woman and her unborn child, in serious jeopardy;
2. Serious impairment to bodily function;
3. Serious dysfunction of any bodily organ or part.

## Dental Solutions through Blue365

OGB members get 20-50% discounts to a network of more than 70,000 dentists for just $6 a month. Members can use the program as often as needed, without limits on the number of visits to a participating dentist. There is no waiting and no red tape to join. You will need to register for Blue365 if you have not already. Visit www.bcbsla.com/OGB to learn more.

## Member ID Card

If you are a new Blue Cross member or change your existing Blue Cross plan, we will issue you new ID cards. Your ID card includes the following:

- Your member number
- Your physician and specialist copayment amounts or deductible/coinsurance
- Customer Service and authorization telephone numbers
- Prescription drug information

Please remember to carry your ID card with you at all times for instant recognition from your providers. If you lose your ID card, please call our Customer Service Department at (800) 392-4089 for a new ID card or email us at ogbhelp@bcbsla.com.

## Your Right to Appeal

If you or your provider disagree with a contractual/benefits denial decision Blue Cross has made about covered services, you have the right to appeal. You can submit appeals by writing to:

**Blue Cross and Blue Shield of Louisiana - Customer Service Unit**
**Appeals and Grievance Coordinator**
**P.O. Box 98045**
**Baton Rouge, LA 70898-9045**

If you or your provider disagree with a clinical decision regarding Not Medically Necessary or an Investigational denial that Blue Cross has made, you have the right to appeal. You can submit appeals by fax or in writing to:

**Blue Cross and Blue Shield of Louisiana**
**Medical Appeals Department**
**P.O. Box 98022**
**Baton Rouge, LA 70898-9022**

If a member has questions or needs assistance putting the appeal in writing, he or she may call Customer Service at (800) 392-4089.

## Authorization of Inpatient Admissions, Emergency Admissions and Outpatient Services

Inpatient Admissions must be Authorized. 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 (800) 392-4089.

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

**The following services and supplies require Authorization prior to the services being rendered or supplies being received. Call Blue Cross and Blue Shield of Louisiana at (800) 392-4089 to request Authorization.**

- 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
- Air Ambulance – Non-Emergency
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- CT Scans
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300)
- Electric & Custom Wheelchairs
- Gene Therapy
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000, 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
- Low-Protein Food Products, if covered
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery
- Organ Transplant Evaluation
- Orthotic Devices (greater than $300)
- Outpatient Pain Rehabilitation or Pain Control Programs
- Partial Hospitalization Programs
- PET Scans
- Physical/Occupational Therapy (Greater than 50 visits)
- Prosthetic Appliances (greater than $300)
- Pulmonary Rehabilitation
- Residential Treatment Centers
- Sleep Studies - except performed in home
- Specialty Pharmacy (complete list of drugs available online at www.bcbsla.com/pharmacy > Find a Drug > Specialty Pharmacy Program Drug List)
- Vacuum Assisted Wound Closure Therapy

# Balance Billing Disclosure

Blue Cross and Blue Shield of Louisiana is required by law to send the notice below to all members when they enroll and once each year they are a member. The notice is provided as a reminder to make sure you choose a doctor or hospital in your provider network when you need healthcare. By choosing a network provider, you avoid the possibility that your provider will bill you for amounts in addition to applicable copayments, coinsurance, deductibles and non-covered services (this is known as "balance billing").

## Balance Billing Disclosure Notice:

Healthcare services may be provided to you at a network healthcare facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for co-payments, coinsurance, deductibles and non-covered services.

Specific information about in-network and out-of network facility-based physicians can be found at www.bcbsla.com or by calling the customer service telephone number of your health plan: (800) 392-4089.