2015 ANNUAL ENROLLMENT GUIDE

State of Louisiana Employees and Retirees
Administered by Blue Cross and Blue Shield of Louisiana
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td><strong>PELICAN HRA 1000</strong></td>
<td>3-15</td>
</tr>
<tr>
<td><strong>PELICAN HSA 775</strong></td>
<td>17-27</td>
</tr>
<tr>
<td><strong>MAGNOLIA LOCAL</strong></td>
<td>29-41</td>
</tr>
<tr>
<td><strong>MAGNOLIA LOCAL PLUS</strong></td>
<td>43-55</td>
</tr>
<tr>
<td><strong>MAGNOLIA OPEN ACCESS</strong></td>
<td>57-71</td>
</tr>
<tr>
<td>Applies to ALL Plans</td>
<td>72-83</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Benefits</td>
<td>72</td>
</tr>
<tr>
<td>Provider Network</td>
<td>73</td>
</tr>
<tr>
<td>Care Management Programs</td>
<td>75</td>
</tr>
<tr>
<td>General Information</td>
<td>77</td>
</tr>
<tr>
<td>Online Tools</td>
<td>78</td>
</tr>
<tr>
<td>Wellness Programs</td>
<td>80</td>
</tr>
<tr>
<td>Healthy Discounts</td>
<td>82</td>
</tr>
<tr>
<td><strong>Balance Billing Disclosure</strong></td>
<td>84</td>
</tr>
</tbody>
</table>

*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.*
Blue Cross and Blue Shield of Louisiana is proud to serve your healthcare needs. Your Blue Cross plan offers many benefits and features, including:

- 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 new 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

Service...

Blue Cross is committed to meeting the challenging demands of healthcare in the 21st century. As part of this commitment, we constantly strive for excellence in customer service. Our goal is to bring Blue Cross plan members the high level of service they expect and deserve. Survey results from polling the state of Louisiana employees and retirees reveal that 89 percent of those members were satisfied overall with their Blue Cross experience.

Ready to Enroll?

- Visit the OGB online enrollment portal at www.annualenrollment.groupbenefits.org, or
- Complete the paper annual enrollment form, or
- Contact human resources if you are an active employee or OGB if you are a retiree.
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 HRA 1000
**SCHEDULE OF BENEFITS:** Actives, Retirees without Medicare, Retirees With Medicare

**Nationwide Network Coverage**

Preferred Care Providers and BCBS National Providers

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

**Benefit Period:** ................................................................................................................................. 03/01/15 – 12/31/15

**Deductible Amount per Benefit Period:**

<table>
<thead>
<tr>
<th></th>
<th><strong>Network</strong></th>
<th><strong>Non-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000.00</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000.00</td>
<td>$8,000.00</td>
</tr>
</tbody>
</table>

**SPECIAL NOTES**

**Deductible Amount**

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

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

**Coinsurance:**

<table>
<thead>
<tr>
<th></th>
<th><strong>Plan</strong></th>
<th><strong>Plan Participant</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-Network Providers</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Out-of-Pocket Maximum per Benefit Period:**

<table>
<thead>
<tr>
<th></th>
<th><strong>Network</strong></th>
<th><strong>Non-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$5,000.00</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>Family</td>
<td>$10,000.00</td>
<td>$20,000.00</td>
</tr>
</tbody>
</table>
SPECIAL NOTES

Out-of-Pocket Maximum

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 to 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 to the Out-of-Pocket Maximum for Network Providers.

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

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

Eligible Expenses

Eligible Expenses are reimbursed in accordance with a fee schedule of maximum Allowable Charges; not billed charges.

All Eligible Expenses are determined in accordance with plan Limitations and Exclusions.

Eligibility

The Plan Administrator assigns Eligibility to all Plan Participants.
<table>
<thead>
<tr>
<th>Category</th>
<th>Network Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visits including surgery performed in an office setting:</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>• General Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Internal Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• OB/GYN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health/Other Office Visits</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Chiropractors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retail Health Clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nurse Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician’s Assistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Office Visits including surgery performed in an office setting.</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Podiatrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Optometrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Audiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Registered Dietician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sleep Disorder Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services (For Emergency Medical Transportation Only)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Ground Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Air Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgical Center and Outpatient Surgical Facility</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Autism Spectrum Disorders (ASD) – Office Visits</td>
<td>80% - 20%&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Autism Spectrum Disorders(ASD) – Inpatient Hospital</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Birth Control Devices - Insertion and Removal (As listed in the Preventive and Wellness Article in the Benefit Plan.)</td>
<td>100% - 0%</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Cardiac Rehabilitation (Must begin within six months of qualifying event; Limit of 26 Visits per Plan Year)</td>
<td>80% - 20%&lt;sup&gt;1,2,3&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2,3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Network Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician’s office.)</td>
<td>80% - 20%¹,²</td>
<td>60% - 40%¹,²</td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>80% - 20%¹</td>
<td>60% - 40%¹</td>
</tr>
<tr>
<td>Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities</td>
<td>80% - 20%¹</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dialysis</td>
<td>80% - 20%¹,²</td>
<td>60% - 40%¹,²</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices</td>
<td>80% - 20%¹,²</td>
<td>60% - 40%¹,²</td>
</tr>
<tr>
<td>Emergency Room (Facility Charge)</td>
<td>80% - 20%¹</td>
<td>80% - 20%¹</td>
</tr>
<tr>
<td>Emergency Medical Services (Non-Facility Charge)</td>
<td>80% - 20%¹</td>
<td>80% - 20%¹</td>
</tr>
<tr>
<td>Flu Shots and H1N1 vaccines (Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)</td>
<td>100% - 0%</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older.)</td>
<td>80% - 20%¹,³</td>
<td>Not Covered</td>
</tr>
<tr>
<td>High-Tech Imaging – Outpatient (CT Scans, MRI/MRA, Nuclear Cardiology, PET Scans)</td>
<td>80% - 20%¹,²</td>
<td>60% - 40%¹,²</td>
</tr>
<tr>
<td>Home Health Care (Limit of 60 Visits per Plan Year, combination of Network and Non-Network) (One Visit = 4 hours)</td>
<td>80% - 20%¹,²</td>
<td>60% - 40%¹,²</td>
</tr>
<tr>
<td>Hospice Care (Limit of 180 Days per Plan Year, combination of Network and Non-Network)</td>
<td>80% - 20%¹,²</td>
<td>60% - 40%¹,²</td>
</tr>
<tr>
<td>Injections Received in a Physician’s Office (When no other health services is received) per injection</td>
<td>80% - 20%¹ per injection</td>
<td>60% - 40%¹ per injection</td>
</tr>
<tr>
<td>Inpatient Hospital Admission (All Inpatient Hospital services included)</td>
<td>80% - 20%¹,²</td>
<td>60% - 40%¹,²</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Services</td>
<td>80% - 20%¹</td>
<td>60% - 40%¹</td>
</tr>
</tbody>
</table>

¹Subject to Plan Year Deductible
²Pre-Authorization Required
³Age and/or time restrictions apply
<table>
<thead>
<tr>
<th>Service Description</th>
<th>COINSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NETWORK PROVIDERS</strong></td>
<td>80% - 20%</td>
</tr>
<tr>
<td><strong>NON-NETWORK PROVIDERS</strong></td>
<td>60% - 40%</td>
</tr>
<tr>
<td>Mastectomy Bras - Ortho-Mammary Surgical (Limited to two (2) per Plan Year)</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Inpatient Treatment</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Outpatient Treatment</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>Newborn – Sick, Services excluding Facility</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>Newborn – Sick, Facility</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>Oral Surgery for Impacted Teeth (Authorization is not required when performed in Physician’s office.)</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>Pregnancy Care – Physician Services</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>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.)</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Rehabilitation Services – Outpatient:</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>• Speech</td>
<td>60% - 40%</td>
</tr>
<tr>
<td>• Physical/Occupational&lt;sup&gt;2&lt;/sup&gt; (Limit of 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.)</td>
<td>60% - 40%</td>
</tr>
<tr>
<td>• Pulmonary Therapies&lt;sup&gt;1&lt;/sup&gt; (Limit 30 Visits per Plan Year)</td>
<td>60% - 40%</td>
</tr>
<tr>
<td>Skilled Nursing Facility&lt;sup&gt;3&lt;/sup&gt; (Limit of 90 days per Plan Year)</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>Sonograms and Ultrasounds - Outpatient</td>
<td>80% - 20%</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>80% - 20%</td>
</tr>
</tbody>
</table>

<sup>1</sup> Subject to Plan Year Deductible
<sup>2</sup> Pre-Authorization Required
<sup>3</sup> Age and/or time restrictions apply
ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

Authorization is Required Prior to Services Being Performed

Organ, Tissue and Bone Marrow Transplants and evaluation for a Plan Participant’s suitability for Organ, Tissue Bone Marrow transplants will not be covered unless a Plan Participant obtains written authorization from the Claims Administrator, prior to services being rendered.

Network Benefits………………………………………………………………………………………………………………………………………………………………….. 80% - 20%
Non-Network Benefits ……………………………………………………………………………………………………………………………………………………………………..Not Covered

CARE MANAGEMENT

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

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

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

Authorization of Inpatient and Emergency Admissions

Inpatient Admissions must be Authorized. Refer to “Care Management” and if applicable “Pregnancy Care and Newborn Care Benefits” sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with the other Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Deductible and Coinsurance percentage.
If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the amount shown below. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

Additional Plan Participant responsibility if Authorization is not requested for an Inpatient Admission to a Non-Network Provider Hospital: FIFTY PERCENT (50%) reduction of the Allowable Charges.

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

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

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.

Authorization of Outpatient Services, Including Other Services and Supplies

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

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Deductible and Coinsurance percentage.

If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the amount shown below. This penalty applies to all services and supplies requiring an Authorization. The Plan Participant is responsible for all charges not covered and remains responsible for his Deductible and applicable Coinsurance percentage.

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

- Air Ambulance – Non-Emergency
- Applied Behavior Analysis
- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Day Rehabilitation Programs
- Dialysis
- Durable Medical Equipment (Greater than $300.00)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump
- Infusion Therapy (Exception: Infusion Therapy performed in a Physician’s office does not require prior Authorization. The Drug to be infused may require prior Authorization).
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician’s office)
- Organ Transplant Evaluation
- Orthotic Devices (Greater than $300.00)
- Outpatient surgical procedures not performed in a Physician’s office
- Outpatient pain rehabilitation or pain control programs
- Partial Hospitalization Programs
- PET Scans
- Physical/Occupational Therapy (Greater than 50 visits)
- Prosthetic Appliances (Greater than $300.00)
- Residential Treatment Centers
- Sleep Studies
- Specialty Pharmacy (Complete list of drugs available online at www.bcbsla.com> I’m a Provider>Pharmacy Management>Specialty Pharmacy Program Drug List.pdf)
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Vacuum Assisted Wound Closure Therapy

Population Health – In Health: Blue Health

The Population Health program targets populations with one or more of these five (5) chronic health conditions – diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). (The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.) Through the In Health: Blue Health Services program, OGB offers an incentive to Plan Participants on Prescription Drugs used to treat the five chronic conditions listed above.

a. OGB Plan Participants participating in the program qualify for $0 Copayment for certain Generic Prescription Drugs approved by the U. S. Food and Drug Administration (FDA) for any of the 5 chronic health conditions.

b. OGB Plan Participants participating in the program qualify for $15 Copayment for certain Brand-Name Prescription Drugs for which an FDA-approved Generic version is not available.

c. If a Generic is available and the OGB Plan Participant chooses the Brand-Name Drug, the OGB Plan Participant pays the difference between the Brand-Name and Generic cost plus the $15 Brand-Name Copayment.

The In Health: Blue Health Services prescription incentive does not apply to any Prescription Drugs not used to treat one of these five health conditions with which you have been diagnosed. Please refer to the Care Management article, Population Health – In Health: Blue Health section of the Benefit Plan for complete information on how to qualify for this incentive.
PRESRIPTION DRUGS

Prescription Drug Benefits are provided under the Hospital Benefits and Medical and Surgical Benefits Articles of the medical plan, and under the Pharmacy Plan provided by OGB’s Pharmacy Benefits Manager (sometimes “PBM”).

Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana provides Claims Administration services only for Prescription Drugs dispensed as follows:

Prescription Drugs Covered Under Hospital Benefits and Medical and Surgical Benefits

1. Prescription Drugs dispensed during an Inpatient or Outpatient Hospital stay, or in an Ambulatory Surgical Center are payable under the Hospital Benefits.

2. Medically necessary/non-investigational Prescription Drugs requiring parenteral administration in a Physician’s Office are payable under the Medical and Surgical Benefits.

3. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician’s office are payable under the Medical and Surgical Benefits.

Authorizations

The following Prescription Drug categories require Prior Authorization. The Plan Participant’s Physician must call 1-800-842-2015 to obtain Authorization. The Plan Participant or his Physician should call the Customer Service number on the back of the ID card, or go to the Claims Administrator’s website at www.bcbsla.com/ogb for the most current list of Prescription Drugs that require Prior Authorization:

- Growth hormones*
- Anti-tumor necrosis factor drugs*
- Intravenous immune globulins*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*

* Shall include all drugs that are in this category.

Therapeutic/Treatment Vaccines – Examples include, but are not limited to vaccines to treat the following conditions:

- Allergic Rhinitis
- Alzheimer’s Disease
- Cancers
- Multiple Sclerosis

Therapeutic/Treatment Vaccines

Network Provider: .................................................................................................................. 100% - 0%

Non-Network Provider: ........................................................................................................ 70% - 30% (After Deductible is Met)
OGB’S Pharmacy Benefits Manager

MedImpact Formulary: 3-Tier Plan Design*

OGB will begin using the MedImpact Formulary to help Plan Participants select the most appropriate, lowest-cost options. The formulary is reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. Plan Participants will continue to pay a portion of the cost of their prescriptions in the form of a copayment or coinsurance. The amount Plan Participants pay toward their prescription depends on whether they receive a generic, preferred brand or non-preferred brand name drug.

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

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG</th>
<th>PLAN PARTICIPANT PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>50% up to $30</td>
</tr>
<tr>
<td>Preferred</td>
<td>50% up to $55</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>65% up to $80</td>
</tr>
<tr>
<td>Specialty</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

The pharmacy out-of-pocket maximum has been changed from $1,200 to $1,500. Once met:

<table>
<thead>
<tr>
<th>GENERIC</th>
<th>PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$0 co-pay</td>
</tr>
<tr>
<td>Preferred</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>Specialty</td>
<td>$40 co-pay</td>
</tr>
</tbody>
</table>

There may be more than one drug available to treat your condition. We encourage you to speak with your Physician regularly about which drugs meet your needs at the lowest cost to you.

Compound Drugs

Compound Drugs over $400 require prior Authorization from MedImpact.

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

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

Over-the-counter drugs

Medications available over-the-counter in the same prescribed strength will no longer be covered under the pharmacy plan.
What is a formulary?

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

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

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

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

- Specialty medications – higher cost drugs.

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

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

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

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

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

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

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

4. Retirees with Medicare will be automatically enrolled in OGB’s Medicare Part D coverage with a commercial wrap benefit.
5. In addition, this Plan allows Benefits limited to $200.00 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are Medically Necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to Coinsurance and Copayments relating to Prescription Drug Benefits. In connection with this Benefit, the following words shall have the following meanings:

a. “Inherited metabolic disease” shall mean a disease caused by an inherited abnormality of body chemistry and shall be limited to:
   - Phenylketonuria (PKU)
   - Maple Syrup Urine Disease (MSUD)
   - Methylmalonic Acidemia (MMA)
   - Isovaleric Acidemia (IVA)
   - Propionic Acidemia
   - Glutaric Acidemia
   - Urea Cycle Defects
   - Tyrosinemia

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

6. Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are not subject to the Prescription Drug deductible and are covered at 100%. Smoking cessation screening and counseling are covered under the Preventive or Wellness Care article of the Benefit Plan.

7. The following drugs, medicines, and related services and supplies are not covered:
   - Drugs used to treat anorexia, weight loss or weight gain
   - Drugs used to promote fertility
   - Dietary supplements;
   - Medical Foods
   - Bulk Chemicals
   - Drugs for cosmetic purposes or to promote hair growth
   - Nutritional or parenteral therapy;
   - Vitamins and minerals;
   - Drugs available over the counter (OTC) (unless expressly covered by this Plan)
   - Prescription drugs (federal legend) with an OTC equivalent

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

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

Lifetime Maximum Benefit: ................................................................. Unlimited
Benefit Period: .............................................................................. 03/01/15 – 12/31/15

Deductible Amount per Benefit Period:

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000.00</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000.00</td>
<td>$8,000.00</td>
</tr>
</tbody>
</table>

SPECIAL NOTES

Deductible Amounts

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:

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Plan Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Providers</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-Network Providers</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Out-of-Pocket Maximum per Benefit Period:

<table>
<thead>
<tr>
<th></th>
<th>Network Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes all eligible Coinsurance Amounts, Deductibles and Prescription Drug Copayments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$5,000.00</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>Family</td>
<td>$10,000.00</td>
<td>$20,000.00</td>
</tr>
</tbody>
</table>
SPECIAL NOTES

Out-of-Pocket Maximum

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 to 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 to the Out-of-Pocket Maximum for Network Providers.

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

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

Eligible Expenses

Eligible Expenses are reimbursed in accordance with a fee schedule of maximum Allowable Charges; not billed charges.

All Eligible Expenses are determined in accordance with plan Limitations and Exclusions.

Eligibility

The Plan Administrator assigns Eligibility to all Plan Participants.
## COINSURANCE

<table>
<thead>
<tr>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician’s Office Visits including surgery performed in an office setting:</strong></td>
<td></td>
</tr>
<tr>
<td>- General Practice</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>- Family Practice</td>
<td></td>
</tr>
<tr>
<td>- Internal Medicine</td>
<td></td>
</tr>
<tr>
<td>- OB/GYN</td>
<td></td>
</tr>
<tr>
<td>- Pediatrics</td>
<td></td>
</tr>
<tr>
<td><strong>Allied Health/Other Office Visits</strong></td>
<td></td>
</tr>
<tr>
<td>- Chiropractors</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>- Retail Health Clinics</td>
<td></td>
</tr>
<tr>
<td>- Nurse Practitioner</td>
<td></td>
</tr>
<tr>
<td>- Physician’s Assistant</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Office Visits including surgery performed in an office setting.</strong></td>
<td></td>
</tr>
<tr>
<td>- Physician</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>- Podiatrist</td>
<td></td>
</tr>
<tr>
<td>- Optometrist</td>
<td></td>
</tr>
<tr>
<td>- Midwife</td>
<td></td>
</tr>
<tr>
<td>- Audiologist</td>
<td></td>
</tr>
<tr>
<td>- Registered Dietician</td>
<td></td>
</tr>
<tr>
<td>- Sleep Disorder Clinic</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td></td>
</tr>
<tr>
<td><em>(For Emergency Medical Transportation Only)</em></td>
<td></td>
</tr>
<tr>
<td>- Ground Transportation</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>- Air Ambulance</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulatory Surgical Center and Outpatient Surgical Facility</strong></td>
<td></td>
</tr>
<tr>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Autism Spectrum Disorders (ASD) – Office Visits</strong></td>
<td></td>
</tr>
<tr>
<td>80% - 20%&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible

<sup>2</sup>Pre-Authorization Required

<sup>3</sup>Age and/or time restrictions apply
## Coinsurance

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Spectrum Disorders (ASD) – Inpatient Hospital</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Birth Control Devices - Insertion and Removal (As listed in the Preventive and Wellness Article in the Benefit Plan.)</td>
<td>100% - 0%</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Cardiac Rehabilitation (Must begin within six months of qualifying event; Limited to 26 visits per Plan Year)</td>
<td>80% - 20%&lt;sup&gt;1,2,3&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2,3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician’s office.)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dialysis</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Emergency Room (Facility Charge)</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Emergency Medical Services (Non-Facility Charge)</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Flu Shots and H1N1 vaccines (Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)</td>
<td>100% - 0%</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older.)</td>
<td>80% - 20%&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>Not Covered</td>
</tr>
<tr>
<td>High-Tech Imaging – Outpatient (CT Scans, MRI/MRA, Nuclear Cardiology, PET Scans)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Home Health Care (Limit of 60 Visits per Plan Year, Combination of Network and Non-Network) (One Visit = 4 hours)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply
## COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care (Limit of 180 Days per Plan Year, combination of Network and Non-Network)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Injections Received in a Physician’s Office (When no other health services is received)</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt; per injection</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt; per injection</td>
</tr>
<tr>
<td>Inpatient Hospital Admission (All Inpatient Hospital services included)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Services</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mastectomy Bras - Ortho-Mammary Surgical (Limited to two (2) per Plan Year)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Inpatient Treatment</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Outpatient Treatment</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Newborn – Sick, Services excluding Facility</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Newborn – Sick, Facility</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Oral Surgery for Impacted Teeth (Authorization is not required when performed in Physician’s office.)</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pregnancy Care – Physician Services</td>
<td>80% - 20%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>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.)</td>
<td>100% - 0%&lt;sup&gt;3&lt;/sup&gt;</td>
<td>100% - 0%&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply
### COINSURANCE

<table>
<thead>
<tr>
<th>Rehabilitation Services – Outpatient:</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Speech</td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>60% - 40%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Physical/Occupational&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Limit of 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pulmonary Therapies (Limit 30 Visits per Plan Year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Visit limits are combination of Network and Non-Network Benefits; Visit limits do not apply when services are provided for Autism Spectrum Disorders.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Skilled Nursing Facility (Limit of 90 days per Plan Year) | 80% - 20%<sup>1,2</sup> | 60% - 40%<sup>1,2</sup> |
| Sonograms and Ultrasounds - Outpatient | 80% - 20%<sup>1</sup> | 60% - 40%<sup>1</sup> |
| Urgent Care Center | 80% - 20%<sup>1</sup> | 60% - 40%<sup>1</sup> |
| Vision Care (Non-Routine) Exam | 80% - 20%<sup>1</sup> | 60% - 40%<sup>1</sup> |
| X-Ray and Laboratory Services | 80% - 20%<sup>1</sup> | 60% - 40%<sup>1</sup> |

<sup>1</sup>Subject to Plan Year Deductible  
<sup>2</sup>Pre-Authorization Required  
<sup>3</sup>Age and/or time restrictions apply

### ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

**Authorization is required prior to services being rendered.**

Organ, Tissue and Bone Marrow Transplants and evaluation for a Plan Participant’s suitability for Organ, Tissue Bone Marrow transplants will not be covered unless a Plan Participant obtains written authorization from the Claims Administrator, prior to services being rendered.

- Network Benefits .......................................................... 80% - 20%
- Non-Network Benefits ........................................................ Not Covered
CARE MANAGEMENT

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

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

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

Authorization of Inpatient and Emergency Admissions

Inpatient Admissions must be Authorized. Refer to “Care Management” and if applicable “Pregnancy Care and Newborn Care Benefits” sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider’s contract with the other Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Deductible and Coinsurance percentage.

If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the amount shown below. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

Additional Plan Participant responsibility if Authorization is not requested for an Inpatient Admission to a Non-Network Provider Hospital: FIFTY PERCENT (50%) reduction of the Allowable Charges.

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

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

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.
Authorization of Outpatient Services, Including Other Services and Supplies

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

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Deductible and Coinsurance percentage.

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

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

- Air Ambulance – Non-Emergency
- Applied Behavior Analysis
- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Day Rehabilitation Programs
- Dialysis
- Durable Medical Equipment (Greater than $300.00)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump
- Infusion Therapy (Exception: Infusion Therapy performed in a Physician’s office does not require prior Authorization. The Drug to be infused may require prior Authorization).
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician’s office)
- Organ Transplant Evaluation
- Orthotic Devices (Greater than $300.00)
- Outpatient surgical procedures not performed in a Physician’s office
- Outpatient pain rehabilitation or pain control programs
- Partial Hospitalization Programs
- PET Scans
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (Greater than $300.00)
- Residential Treatment Centers
- Sleep Studies
- Specialty Pharmacy (Complete list of drugs available online at www.bcbsla.com> I’m a Provider>Pharmacy Management>Specialty Pharmacy Program Drug List.pdf)
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Vacuum Assisted Wound Closure Therapy
Population Health – In Health: Blue Health

The Population Health program targets populations with one or more of these five (5) chronic health conditions – diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). (The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.) Through the In Health: Blue Health Services program, OGB offers an incentive to Plan Participants on Prescription Drugs used to treat the five chronic conditions listed above.

a. OGB Plan Participants participating in the program qualify for $0 Copayment for certain Generic Prescription Drugs approved by the U. S. Food and Drug Administration (FDA) for any of the 5 chronic health conditions.

b. OGB Plan Participants participating in the program qualify for $15 Copayment for certain Brand-Name Prescription Drugs for which an FDA-approved Generic version is not available.

c. If a Generic is available and the OGB Plan Participant chooses the Brand-Name Drug, the OGB Plan Participant pays the difference between the Brand-Name and Generic cost plus the $15 Brand-Name Copayment.

The In Health: Blue Health Services prescription incentive does not apply to any Prescription Drugs not used to treat one of these five health conditions with which you have been diagnosed. Please refer to the Care Management article, Population Health – In Health: Blue Health section of the Benefit Plan for complete information on how to qualify for this incentive.

PRESCRIPTION DRUGS

Blue Cross and Blue Shield of Louisiana (BCBSLA) works in partnership with Express Scripts®, an independent pharmacy benefits management company, to administer your prescription drug program for the OGB Consumer Driven Health Plan (CDHP).

RETAIL AND MAIL ORDER - Subject to Deductible and applicable Copayments:

- $10 Copayment per 31 day supply – Generic (Up to a 93 day supply/3 Copayments)
- $25 Copayment per 31 day supply – Preferred Brand (Up to a 93 day supply/3 Copayments)
- $50 Copayment per 31 day supply – Non-Preferred Brand (Up to a 93 day supply/3 Copayments)
- $50 Copayment per 31 day supply – Specialty (Up to a 31 day supply/1 Copayment)

Select Maintenance Drugs (Up to a 93 day supply) Not subject to deductible: Copayments same as above.

ESI’s Maintenance/Preventive List is a list of the most commonly prescribed preventive drugs and is not all-inclusive. Please refer to ESI’s Maintenance/Preventive Drug List for more information. www.bcbsla.com/ogb.

If the Plan Participant chooses to purchase a Brand-Name prescription for which an approved Generic is available, the Plan Participant will pay the cost difference between the Brand-Name Drug and the Generic version, plus the Preferred Brand-Name Copayment.

Benefits are available for contraceptive drugs.

Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance.
Compound Drugs

Authorization is required for Compound Drugs over $400.00

Growth Hormone Therapy

Benefits are available for growth hormone therapy for the treatment of chronic renal insufficiency, AIDS wasting, Turners Syndrome, Prader-Willi syndrome, Noonan Syndrome, wound healing in burn patients, growth delay in patients with severe burns, short bowel syndrome, short stature homeobox-containing gene (SHOX) deficiency, or growth hormone deficiency when a Physician confirms the growth hormone deficiency with abnormal provocative stimulation testing.

Smoking Cessation Medications

Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a Physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.

Prescription Drug Step Therapy

*Lead with Generics*, our prescription step therapy program, promotes the use of Generic Drugs as your first step to treat your condition. The program is designed to help you get effective treatment while keeping your Prescription Drugs affordable. *Lead with Generics* requires you to try a Generic option or similar alternative medication (in certain drug classes) before you use a Brand-Name Drug.

For example, if Drug A and Drug B both treat the Plan Participant’s medical condition, the Plan may require the Plan Participant’s Physician to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Plan will cover a prescription written for Drug B. However, if Your Physician’s request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B Brand-Name Drug included in the Step Therapy program without first trying a Step A Generic alternative, You will be responsible for the full cost of the drug.

Categories of Prescription Drugs that require Step Therapy

As these categories may change from time to time, the Plan Participant should call the customer service number on their ID card or check our website at [www.bcbsla.com](http://www.bcbsla.com) to determine what categories of Prescription Drugs are subject to step therapy. Examples may include but are not limited to the following:

- Blood Pressure Medications: (example: Angiotensin Converting Enzyme Inhibitors, Angiotensin II Receptor Blockers, Direct Renin Inhibitors)
- Pain Medications: (example: Non-Steroidal Anti-Inflammatory Drugs, COX-2 Inhibitors)
- Cholesterol Medications: (example: HMG-CoA Reductase Inhibitors)
- Sleep Medications: (example: Sedatives, Hypnotics)
- Stomach Acid Medications: (example: Proton Pump Inhibitors)
- Respiratory/Allergy Medications: (example: Nasal Antihistamines, Non-Sedating Antihistamines, Nasal Steroids)
- Depression Medications: (example: Selective Serotonin Reuptake Inhibitors, Serotonin/Norepinephrine Reuptake Inhibitors)
- Frequent Urination Medications: (example: Antimuscarinics)
- Long-Acting Pain Medications: (example: Opiate Analgesics)
- Acne Treatment Medications: (example: Tetracycline Antibiotics)
- Oral Diabetes Medications: (example: Biguanides, Thiazolidinediones)
- Bone Medications: (example: Bisphosphonates)
- Migraine Medications: (example: Selective Serotonin Receptor Agonists)
- Topical Acne Medications: (example: Topical Antibiotics, Retinoid Compounds)
- Topical Corticosteroids
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.
**SCHEDULE OF BENEFITS:** Actives, Retirees Without Medicare, Retirees With Medicare

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

Blue Connect and Community Blue

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Period:</th>
<th>Deductible Amount Per Benefit Period:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum Benefit:</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>Benefit Period:</strong></td>
<td>03/01/2015 – 12/31/2015</td>
<td></td>
</tr>
</tbody>
</table>

**Individual:**

**Network Providers:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Deductible Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)</td>
<td>$400.00</td>
</tr>
<tr>
<td>Retirees prior to 03/01/15 (With and Without Medicare)</td>
<td>$0</td>
</tr>
<tr>
<td>Non-Network Providers:</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

**Individual + 1 Dependent:**

**Network Providers:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Deductible Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)</td>
<td>$800.00</td>
</tr>
<tr>
<td>Retirees prior to 03/01/15 (With and Without Medicare)</td>
<td>$0</td>
</tr>
<tr>
<td>Non-Network Providers:</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

**Family (Individual + 2 or more Dependents):**

**Network Providers:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Deductible Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Employees and Retirees on or after 3/1/15 (With and Without Medicare)</td>
<td>$1,200.00</td>
</tr>
<tr>
<td>Retirees prior to 03/01/15 (With and Without Medicare)</td>
<td>$0</td>
</tr>
<tr>
<td>Non-Network Providers:</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>
Out-of-Pocket Maximum per Benefit Period:

<table>
<thead>
<tr>
<th>Includes all eligible Copayments, Coinsurance Amounts, and Deductibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Employees and Retirees on or after 3/1/2015 (With and Without Medicare)</td>
</tr>
<tr>
<td>Network</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Individual + 1 Dependent</td>
</tr>
<tr>
<td>Family (Individual + 2 or more Dependents)</td>
</tr>
</tbody>
</table>

**SPECIAL NOTES**

**Out-of-Pocket Maximum**

When the Out-of-Pocket Maximum, as shown above, has been satisfied, this Plan will pay 100% of the Allowable Charge toward eligible expenses for the remainder of the Plan Year.

**Eligible Expenses**

Eligible Expenses are reimbursed in accordance with a fee schedule of maximum Allowable Charges, not billed charges.

**All Eligible Expenses are determined in accordance with Plan Limitations and Exclusions.**

**Eligibility**

The Plan Administrator determines Eligibility for all Plan Participants.

**Network Coverage**

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

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

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

Blue Connect is a select, local network designed for members who live in the New Orleans community (Orleans and Jefferson parishes).
<table>
<thead>
<tr>
<th>Service Description</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits including surgery performed in an office setting:</td>
<td>$25 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• General Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Family Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Internal Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• OB/GYN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health/Other Professional Visits:</td>
<td>$25 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Chiropractors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Federally Funded Qualified Rural Health Clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nurse Practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retail Health Clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Assistants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Office Visits including surgery performed in an office setting:</td>
<td>$50 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• Physician</td>
<td></td>
<td></td>
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<tr>
<td>• Podiatrist</td>
<td></td>
<td></td>
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<tr>
<td>• Optometrist</td>
<td></td>
<td></td>
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<tr>
<td>• Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Audiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Registered Dietician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sleep Disorder Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services – Ground</td>
<td>$50 Copayment</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Ambulance Services – Air</td>
<td>$250 Copayment²</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Ambulatory Surgical Center and Outpatient Surgical Facility</td>
<td>$100 Copayment²</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Autism Spectrum Disorders (ASD)</td>
<td>$25/$50 Copayment³ per Visit depending on Provider</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan.)</td>
<td>100% - 0%</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

¹Subject to Plan Year Deductible, if applicable
²Pre-Authorization Required, if applicable.
³Not applicable for Medicare primary.
⁴Age and/or Time Restrictions Apply
## COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation <em>(limit of 48 visits per Plan Year)</em></td>
<td>$25/$50 Copayment per day depending on Provider</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>$50 Copayment – Outpatient Facility²</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy/Radiation Therapy <em>(Authorization not required when performed in Physician’s office)</em></td>
<td>Office – $25 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td></td>
<td>Outpatient Facility 100% - 0%¹,²</td>
<td></td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>80% - 20%¹</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities</td>
<td>$25 Copayment</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Dialysis</td>
<td>100% - 0%¹,²</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices</td>
<td>80% - 20%¹,² of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Emergency Room <em>(Facility Charge)</em></td>
<td>$150 Copayment; Waived if Admitted</td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Services <em>(Non-Facility Charges)</em></td>
<td>100% - 0%¹</td>
<td>100% - 0%¹</td>
</tr>
<tr>
<td>Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses <em>(purchased within six months following cataract surgery)</em></td>
<td>Eyeglass Frames – Limited to a Maximum Benefit of $50¹,³</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Flu shots and H1N1 vaccines <em>(administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)</em></td>
<td>100% - 0%</td>
<td>100% - 0%</td>
</tr>
<tr>
<td>Hearing Aids <em>(Hearing Aids are not covered for individuals age eighteen (18) and older.)</em></td>
<td>80% - 20%¹,³</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Hearing Impaired Interpreter expense</td>
<td>100% - 0%¹</td>
<td>No Coverage</td>
</tr>
<tr>
<td>High-Tech Imaging – Outpatient</td>
<td>$50 Copayment²</td>
<td>No Coverage</td>
</tr>
<tr>
<td>• CT Scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MRA/MRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nuclear Cardiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PET/SPECT Scans</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹Subject to Plan Year Deductible, if applicable
²Pre-Authorization Required, if applicable.
Not applicable for Medicare primary.
³Age and/or Time Restrictions Apply
## COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care <em>(limit of 60 Visits per Plan Year)</em></td>
<td>100% - 0%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Hospice Care <em>(limit of 180 Days per Plan Year)</em></td>
<td>100% - 0%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Injections Received in a Physician’s Office <em>(allergy and allergy serum)</em></td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Inpatient Hospital Admission, All Inpatient Hospital Services Included</td>
<td>$100 Copayment per day&lt;sup&gt;2&lt;/sup&gt;, maximum of $300 per Admission</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable</td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Mastectomy Bras – Ortho-Mammary Surgical <em>(limited to two (2) per Plan Year)</em></td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt; of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse – Inpatient Treatment</td>
<td>$100 Copayment per day&lt;sup&gt;2&lt;/sup&gt;, maximum of $300 per Admission</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse – Outpatient Treatment</td>
<td>$25 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Newborn – Sick, Services excluding Facility</td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Newborn – Sick, Facility</td>
<td>$100 Copayment per day&lt;sup&gt;2&lt;/sup&gt;, maximum of $300 per Admission</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Oral Surgery <em>(Authorization not required when performed in Physician’s office)</em></td>
<td>100% - 0%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>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. <em>(For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.)</em></td>
<td>100% - 0%&lt;sup&gt;3&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible, if applicable
<sup>2</sup>Pre-Authorization Required, if applicable.
<sup>3</sup>Not applicable for Medicare primary.
<sup>4</sup>Age and/or Time Restrictions Apply
ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

Authorization is Required Prior to Services Being Performed

Organ, Tissue and Bone Marrow Transplants and evaluation for a Plan Participant’s suitability for Organ, Tissue Bone Marrow transplants will not be covered unless a Plan Participant obtains written authorization from the Claims Administrator, prior to services being rendered.

Network Benefits: ......................................................................................................................... 100% - 0% after deductible
Non-Network Benefits: .........................................................................................................................Not Covered

CARE MANAGEMENT

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

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Plan Participant must pay all charges incurred.
If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the Network status of the Provider rendering the services.

**Authorization of Inpatient and Emergency Admissions**

Inpatient Admissions must be Authorized. Refer to “Care Management” and if applicable “Pregnancy Care and Newborn Care Benefits” sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Copayment or Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

If Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider’s contract with the other Blue Cross and Blue Shield plan. This penalty applies to covered Inpatient charges. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

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

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

**Authorization of Outpatient Services, Including Other Services and Supplies:**

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

If Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

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

- Air Ambulance – Non Emergency
- Applied Behavior Analysis
- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Day Rehabilitation Programs
- Dialysis
- Durable Medical Equipment (Greater than $300.00)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
• Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump
• Infusion Therapy (Exception: Infusion Therapy performed in a Physician’s office does not require prior Authorization. The Drug to be infused may require prior Authorization).
• Intensive Outpatient Programs
• MRI/MRA
• Nuclear Cardiology
• Oral Surgery (not required when performed in a Physician’s office)
• Organ Transplant Evaluation
• Orthotic Devices (Greater than $300.00)
• Outpatient surgical procedures not performed in a Physician’s office
• Outpatient non-surgical procedures (Exceptions: X-rays, lab work, Speech Therapy and Chiropractic Services do not require prior Authorization. Non-surgical procedures performed in a Physician's office do not require prior Authorization).
• Outpatient pain rehabilitation or pain control programs
• Partial Hospitalization Programs
• PET/SPCET Scans
• Physical/Occupational Therapy (greater than 50 visits)
• Prosthetic Appliances (Greater than $300.00)
• Residential Treatment Centers
• Sleep Studies
• Specialty Pharmacy (Complete list of drugs available online at www.bcbsla.com> I'm a Provider>Pharmacy Management>Specialty Pharmacy Program Drug List.pdf)
• Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
• Vacuum Assisted Wound Closure Therapy

Population Health – In Health: Blue Health

The Population Health program targets populations with one or more of these five (5) chronic health conditions – diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). (The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.)

Through the In Health: Blue Health Services program, OGB offers an incentive to Plan Participants on Prescription Drugs used to treat the five chronic conditions listed above.

a. OGB Plan Participants participating in the program qualify for $0 Copayment for certain Generic Prescription Drugs approved by the U. S. Food and Drug Administration (FDA) for any of the 5 chronic health conditions.

b. OGB Plan Participants participating in the program qualify for $20 Copayment (31 day supply), $40 Copayment (62 day supply) or $50 Copayment (93 day supply) for certain Preferred Brand-Name Prescription Drugs for which an FDA-approved Generic version is not available.

c. OGB Plan Participants participating in the program qualify for $40 Copayment (31 day supply), $80 Copayment (62 day supply) or $100 Copayment (93 day supply) for certain Non-Preferred Brand-Name Prescription Drug. Non-Preferred drugs typically have lower cost alternatives available in the same drug class.

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

The In Health: Blue Health Services prescription incentive does not apply to any Prescription Drugs not used to treat one of these five health conditions with which you have been diagnosed. Please refer to the Care Management article, Population Health – In Health: Blue Health section of the Benefit Plan for complete information on how to qualify for this incentive.
PRESCRIPTION DRUGS

Prescription Drug Benefits are provided under the Hospital Benefits and Medical and Surgical Benefits Articles of the medical plan, and under the pharmacy plan provided by OGB’s Pharmacy Benefits Manager (sometimes “PBM”).

Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana provides Claims Administration services only for Prescription Drugs dispensed as follows:

Prescription Drugs Covered Under Hospital Benefits and Medical and Surgical Benefits

1. Prescription Drugs dispensed during an Inpatient or Outpatient Hospital stay, or in an Ambulatory Surgical Center are payable under the Hospital Benefits.

2. Medically necessary/non-investigational Prescription Drugs requiring parenteral administration in a Physician’s Office are payable under the Medical and Surgical Benefits.

3. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician’s office are payable under the Medical and Surgical Benefits.

All other pharmacy benefits will be provided by OGB’S PBM.

Authorizations

The following categories of Prescription Drugs require Prior Authorization. The Plan Participant’s Physician must call 1-800-842-2015 to obtain the Authorization. The Plan Participant or his Physician should call the Customer Service number on the Plan Participant’s ID card, or check the Claims Administrator’s website at www.bcbsla.com/ogb for the most current list of Prescription Drugs that require Prior Authorization:

- Growth hormones*
- Anti-tumor necrosis factor drugs*
- Intravenous immune globulins*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*

* Shall include all drugs that are in this category.

Therapeutic/Treatment Vaccines – Examples include, but are not limited to vaccines to treat the following conditions:

- Allergic Rhinitis
- Alzheimer’s Disease
- Cancers
- Multiple Sclerosis

Therapeutic/Treatment Vaccines:

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

OGB’S Pharmacy Benefit Manager

MedImpact Formulary: 3-Tier Plan Design*

OGB will begin using the MedImpact Formulary to help Plan Participants select the most appropriate, lowest-cost options. The formulary is reviewed on a quarterly basis to reassess drug tiers based on the current prescription
drug market. Plan Participants will continue to pay a portion of the cost of their prescriptions in the form of a co-payment or coinsurance. The amount Plan Participants pay toward their prescription depends on whether they receive a generic, preferred brand or non-preferred brand name drug.

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

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG</th>
<th>PLAN PARTICIPANT PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>50% up to $30</td>
</tr>
<tr>
<td>Preferred</td>
<td>50% up to $55</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>65% up to $80</td>
</tr>
<tr>
<td>Specialty</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

The pharmacy out-of-pocket maximum has been changed from $1,200 to $1,500. Once met:

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG</th>
<th>PLAN PARTICIPANT PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$0 co-pay</td>
</tr>
<tr>
<td>Preferred</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>Specialty</td>
<td>$40 co-pay</td>
</tr>
</tbody>
</table>

There may be more than one drug available to treat your condition. We encourage you to speak with your Physician regularly about which drugs meet your needs at the lowest cost to you.

**Compound Drugs**

Compound Drugs over $400 require prior Authorization from MedImpact.

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

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

**Over-the-counter drugs**

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

**What is a formulary?**

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

- A generic drug is effectively equivalent to a brand name drug in intended use, dosage, strength, and safety. For a generic drug to be approved by the FDA, it must meet the same quality standards as the brand name product. Even the generic manufacturing, packaging, and testing sites must meet the same standards. Many generics are produced in the same manufacturing plant as their branded counterparts.
- Preferred brand drugs are generally those that have been on the market for a while and do not have a generic equivalent available. They are effective alternatives to other brands that may be more expensive.
- Non-preferred brand drugs are recently branded medications. In most cases, a lower cost alternative is available.
- Specialty medications – higher cost drugs.
1. In the event the Plan Participant does not present his identification card to the Network pharmacy at the time of purchase, the Plan Participant will be responsible for full payment for the drug and must then file a claim with the Pharmacy Benefits Manager for reimbursement. Reimbursement is limited to the rates established for Non-Network pharmacies.

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

2. Regardless of where the Prescription Drug is obtained, Eligible Expenses for Brand Name Drugs will be limited to:
   a. The Pharmacy Benefits Manager's maximum Allowable Charge for the Generic, when available; or
   b. The Pharmacy Benefits Manager's maximum Allowable Charge for the Brand Drug dispensed, when a Generic is not available.
   c. There is no per prescription maximum on the Plan Participant's responsibility for payment of costs in excess of the Eligible Expense. Plan Participant payments for such excess costs are not applied toward satisfaction of the annual Out-of-Pocket threshold (above).

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

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

5. In addition, this Plan allows Benefits limited to $200.00 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are Medically Necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to Coinsurance and Copayments relating to Prescription Drug Benefits. In connection with this Benefit, the following words shall have the following meanings:
   a. “Inherited metabolic disease” shall mean a disease caused by an inherited abnormality of body chemistry and shall be limited to:
      • Phenylketonuria (PKU)
      • Maple Syrup Urine Disease (MSUD)
      • Methylmalonic Acidemia (MMA)
      • Isovaleric Acidemia (IVA)
      • Propionic Acidemia
      • Glutaric Acidemia
      • Urea Cycle Defects
      • Tyrosinemia
   b. “Low protein food products” mean food products that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include natural foods that are naturally low in protein.
6. Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a Physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are not subject to the Prescription Drug deductible and are covered at 100%.

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

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

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

For more information on the pharmacy benefit, visit the MedImpact website at https://mp.medimpact.com/ogb or call MedImpact member services at 1-800-910-1831.
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.
SCHEDULE OF BENEFITS: Actives, Retirees Without Medicare, Retirees With Medicare

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

Lifetime Maximum Benefit: Unlimited

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

Deductible Amount Per Benefit Period:

Individual:

Network Providers:

Active Employees and Retirees on or after 3/1/15 (With and Without Medicare) $400.00
Retirees prior to 03/01/15 (With and Without Medicare) $0
Non-Network Providers: No Coverage

Individual + 1 Dependent:

Network Providers:

Active Employees and Retirees on or after 3/1/15 (With and Without Medicare) $800.00
Retirees prior to 03/01/15 (With and Without Medicare) $0
Non-Network Providers: No Coverage

Family (Individual + 2 or more Dependents):

Network Providers:

Active Employees and Retirees on or after 3/1/15 (With and Without Medicare) $1,200.00
Retirees prior to 03/01/15 (With and Without Medicare) $0
Non-Network Providers: No Coverage
### Out-of-Pocket Maximum per Benefit Period:

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Employees and Retirees</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>on or after 3/1/2015 (With and Without Medicare)</td>
<td>$2,500</td>
<td>No Coverage</td>
<td>$1,000</td>
<td>No Coverage</td>
</tr>
<tr>
<td><strong>Retirees prior to 3/01/2015 (With and Without Medicare)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$5,000</td>
<td>No Coverage</td>
<td>$2,000</td>
<td>No Coverage</td>
<td></td>
</tr>
<tr>
<td>$7,500</td>
<td>No Coverage</td>
<td>$3,000</td>
<td>No Coverage</td>
<td></td>
</tr>
</tbody>
</table>

### SPECIAL NOTES

**Out-of-Pocket Maximum**

When the Out-of-Pocket Maximum, as shown above, has been satisfied, this Plan will pay 100% of the Allowable Charge toward eligible expenses for the remainder of the Plan Year.

**Eligible Expenses**

Eligible Expenses are reimbursed in accordance with a fee schedule of maximum Allowable Charges, not billed charges.

**All Eligible Expenses are determined in accordance with Plan Limitations and Exclusions.**

**Eligibility**

The Plan Administrator determines Eligibility for all Plan Participants.
### COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits including surgery performed in an office setting:</td>
<td>$25 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>- General Practice</td>
<td></td>
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<tr>
<td>- Family Practice</td>
<td></td>
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<tr>
<td>- Internal Medicine</td>
<td></td>
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<tr>
<td>- OB/GYN</td>
<td></td>
<td></td>
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<tr>
<td>- Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health/Other Professional Visits:</td>
<td>$25 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>- Chiropractors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Federally Funded Qualified Rural Health Clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Nurse Practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Retail Health Clinics</td>
<td></td>
<td></td>
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<tr>
<td>- Physician Assistants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Office Visits including surgery performed in an office setting:</td>
<td>$50 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>- Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Podiatrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Optometrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Audiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Registered Dietician</td>
<td></td>
<td></td>
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<tr>
<td>- Sleep Disorder Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services – Ground</td>
<td>$50 Copayment</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Ambulance Services – Air</td>
<td>$250 Copayment^2</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Ambulatory Surgical Center and Outpatient Surgical Facility</td>
<td>$100 Copayment^2</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Autism Spectrum Disorders (ASD)</td>
<td>$25/$50 Copayment^3 per Visit depending on Provider</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan.)</td>
<td>100% - 0%</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

^1 Subject to Plan Year Deductible, if applicable
^2 Pre-Authorization Required, if applicable. Not applicable for Medicare primary.
^3 Age and/or Time Restrictions Apply
## COPAYMENTS and COINSURANCE

<table>
<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
</table>
| Cardiac Rehabilitation (limit of 48 visits per Plan Year) | $25/$50 Copayment per day depending on Provider  
$50 Copayment – Outpatient Facility<sup>2</sup> | No Coverage                                      |
| Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician’s office) | Office – $25 Copayment per Visit  
Outpatient Facility 100% - 0%<sup>1,2</sup> | No Coverage                                      |
| Diabetes Treatment                   | 80% - 20%<sup>1</sup> | No Coverage                                      |
| Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities | $25 Copayment | No Coverage                                      |
| Dialysis                             | 100% - 0%<sup>1,2</sup> | No Coverage                                      |
| Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices | 80% - 20%<sup>1,2</sup> of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year | No Coverage                                      |
| Emergency Room (Facility Charge)    | $150 Copayment; Waived if Admitted |                                              |
| Emergency Medical Services (Non-Facility Charges) | 100% - 0%<sup>1</sup> | 100% - 0%<sup>1</sup>                          |
| 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<sup>1,3</sup> | No Coverage                                      |
| Flu shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair) | 100% - 0% | 100% - 0%                                      |
| Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older.) | 80% - 20%<sup>1,3</sup> | No Coverage                                      |
| Hearing Impaired Interpreter expense | 100% - 0%<sup>1</sup> | No Coverage                                      |
| High-Tech Imaging – Outpatient       | $50 Copayment<sup>2</sup> | No Coverage                                      |

<sup>1</sup>Subject to Plan Year Deductible, if applicable  
<sup>2</sup>Pre-Authorization Required, if applicable.  
<sup>3</sup>Not applicable for Medicare primary.  
<sup>3</sup>Age and/or Time Restrictions Apply
<table>
<thead>
<tr>
<th>Service Description</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care <em>(limit of 60 Visits per Plan Year)</em></td>
<td>100% - 0%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Hospice Care <em>(limit of 180 Days per Plan Year)</em></td>
<td>100% - 0%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>InjectionsReceived in a Physician’s Office <em>(allergy and allergy serum)</em></td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Inpatient Hospital Admission, All Inpatient Hospital Services Included</td>
<td>$100 Copayment per day&lt;sup&gt;2&lt;/sup&gt;, maximum of $300 per Admission</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable</td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Mastectomy Bras – Ortho-Mammary Surgical <em>(limited to two (2) per Plan Year)</em></td>
<td>80% - 20%&lt;sup&gt;1,2&lt;/sup&gt; of first $5,000 allowable per Plan Year; 100% - 0% of allowable in excess of $5,000 per Plan Year</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse – Inpatient Treatment</td>
<td>$100 Copayment per day&lt;sup&gt;2&lt;/sup&gt;, maximum of $300 per Admission</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse – Outpatient Treatment</td>
<td>$25 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Newborn – Sick, Services excluding Facility</td>
<td>100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Newborn – Sick, Facility</td>
<td>$100 Copayment per day&lt;sup&gt;2&lt;/sup&gt;, maximum of $300 per Admission</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Oral Surgery <em>(Authorization not required when performed in Physician’s office)</em></td>
<td>100% - 0%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Pregnancy Care – Physician Services</td>
<td>$90 Copayment per pregnancy</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

<sup>1</sup> Subject to Plan Year Deductible, if applicable
<sup>2</sup> Pre-Authorization Required, if applicable.
<sup>3</sup> Not applicable for Medicare primary.
<sup>4</sup> Age and/or Time Restrictions Apply
**COPAYMENTS and COINSURANCE**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Network Providers</th>
<th>Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.)</td>
<td>100% - 0%&lt;sup&gt;3&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Rehabilitation Services – Outpatient: Physical/Occupational (Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.) • Speech • Cognitive • Hearing Therapy</td>
<td>$25 Copayment per Visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Skilled Nursing Facility – Network (limit of 90 days per Plan Year)</td>
<td>$100 Copayment per day&lt;sup&gt;2&lt;/sup&gt;, maximum of $300 per Admission</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Sonograms and Ultrasounds (Outpatient)</td>
<td>$50 Copayment</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>$50 Copayment</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Vision Care (Non-Routine) Exam</td>
<td>$25/$50 Copayment depending on Provider</td>
<td>No Coverage</td>
</tr>
<tr>
<td>X-ray and Laboratory Services (low-tech imaging)</td>
<td>Office or Independent Lab 100% - 0% Hospital Facility 100% - 0%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible, if applicable
<sup>2</sup>Pre-Authorization Required, if applicable.
<sup>3</sup>Not applicable for Medicare primary.
<sup>3</sup>Age and/or Time Restrictions Apply
ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

Authorization is Required Prior to Services Being Performed

Organ, Tissue and Bone Marrow Transplants and evaluation for a Plan Participant’s suitability for Organ, Tissue Bone Marrow transplants will not be covered unless a Plan Participant obtains written authorization from the Claims Administrator, prior to services being rendered.

Network Benefits: ......................................................................................................................... 100% - 0% after deductible
Non-Network Benefits: .................................................................................................................. Not Covered

CARE MANAGEMENT

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

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

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

Authorization of Inpatient and Emergency Admissions

Inpatient Admissions must be Authorized. Refer to “Care Management” and if applicable “Pregnancy Care and Newborn Care Benefits” sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions, and for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage shown in the Schedule of Benefits.

If Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider’s contract with the other Blue Cross and Blue Shield plan. This penalty applies to covered Inpatient charges. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

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

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

Authorization of Outpatient Services, Including Other Services and Supplies:

If a Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.
If Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

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

- Air Ambulance – Non Emergency
- Applied Behavior Analysis
- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Day Rehabilitation Programs
- Dialysis
- Durable Medical Equipment (Greater than $300.00)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump
- Infusion Therapy (Exception: Infusion Therapy performed in a Physician’s office does not require prior Authorization. The Drug to be infused may require prior Authorization).
- Intensive Outpatient Programs
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician’s office)
- Organ Transplant Evaluation
- Orthotic Devices (Greater than $300.00)
- Outpatient surgical procedures not performed in a Physician’s office
- Outpatient pain rehabilitation or pain control programs
- Partial Hospitalization Programs
- PET/SPECT Scans
- Physical/Occupational Therapy (Greater than 50 visits)
- Prosthetic Appliances (Greater than $300.00)
- Residential Treatment Centers
- Sleep Studies
- Specialty Pharmacy (Complete list of drugs available online at www.bcbsla.com> I'm a Provider>Pharmacy Management>Specialty Pharmacy Program Drug List.pdf)
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Vacuum Assisted Wound Closure Therapy

**Population Health – In Health: Blue Health**

The Population Health program targets populations with one or more of these five (5) chronic health conditions – diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). (The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.)

Through the In Health: Blue Health Services program, OGB offers an incentive to Plan Participants on Prescription Drugs used to treat the five chronic conditions listed above.

a. OGB Plan Participants participating in the program qualify for $0 Copayment for certain Generic Prescription Drugs approved by the U. S. Food and Drug Administration (FDA) for any of the 5 chronic health conditions.
b. OGB Plan Participants participating in the program qualify for $20 Copayment (31 day supply), $40 Copayment (62 day supply) or $50 Copayment (93 day supply) for certain Preferred Brand-Name Prescription Drugs for which an FDA-approved Generic version is not available.

c. OGB Plan Participants participating in the program qualify for $40 Copayment (31 day supply), $80 Copayment (62 day supply) or $100 Copayment (93 day supply) for certain Non-Preferred Brand-Name Prescription Drug. Non-Preferred drugs typically have lower cost alternatives available in the same drug class.

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

The In Health: Blue Health Services prescription incentive does not apply to any Prescription Drugs not used to treat one of these five health conditions with which you have been diagnosed. Please refer to the Care Management article, Population Health – In Health: Blue Health section of the Benefit Plan for complete information on how to qualify for this incentive.

**PRESCRIPTION DRUGS**

Prescription Drug Benefits are provided under the Hospital Benefits and Medical and Surgical Benefits Articles of the medical plan, and under the Pharmacy Plan provided by OGB’s Pharmacy Benefits Manager (sometimes “PBM”).

**Blue Cross and Blue Shield of Louisiana**

Blue Cross and Blue Shield of Louisiana provides Claims Administration services only for Prescription Drugs dispensed as follows:

**Prescription Drugs Covered Under Hospital Benefits and Medical and Surgical Benefits**

1. Prescription Drugs dispensed during an Inpatient or Outpatient Hospital stay, or in an Ambulatory Surgical Center are payable under the Hospital Benefits.

2. Medically necessary/non-investigational Prescription Drugs requiring parenteral administration in a Physician’s Office are payable under the Medical and Surgical Benefits.

3. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician's office are payable under the Medical and Surgical Benefits.

All other pharmacy benefits will be provided by OGB’S Pharmacy Benefit Manager.

**Authorizations**

The following categories of Prescription Drugs require Prior Authorization. The Plan Participant’s Physician must call 1-800-842-2015 to obtain the Authorization. The Plan Participant or his Physician should call the Customer Service number on the Plan Participant’s ID card, or check the Claims Administrator’s website at www.bcbsla.com/ogb for the most current list of Prescription Drugs that require Prior Authorization:

- Growth hormones*
- Anti-tumor necrosis factor drugs*
- Intravenous immune globulins*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*

* Shall include all drugs that are in this category.
**Therapeutic/Treatment Vaccines** – Examples include, but are not limited to vaccines to treat the following conditions:

- Allergic Rhinitis
- Alzheimer’s Disease
- Cancers
- Multiple Sclerosis

**Therapeutic/Treatment Vaccines:**

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

**OGB’S Pharmacy Benefit Manager**

**MedImpact Formulary: 3-Tier Plan Design**

OGB will begin using the MedImpact Formulary to help Plan Participants select the most appropriate, lowest-cost options. The formulary is reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. Plan Participants will continue to pay a portion of the cost of their prescriptions in the form of a co-pay or co-insurance. The amount Plan Participants pay toward their prescription depends on whether they receive a generic, preferred brand or non-preferred brand name drug.

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

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG</th>
<th>PLAN PARTICIPANT PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>50% up to $30</td>
</tr>
<tr>
<td>Preferred</td>
<td>50% up to $55</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>65% up to $80</td>
</tr>
<tr>
<td>Specialty</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

The pharmacy out-of-pocket maximum has been changed from $1,200 to $1,500. Once met:

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG</th>
<th>PLAN PARTICIPANT PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$0 co-pay</td>
</tr>
<tr>
<td>Preferred</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>Specialty</td>
<td>$40 co-pay</td>
</tr>
</tbody>
</table>

There may be more than one drug available to treat your condition. We encourage you to speak with your Physician regularly about which drugs meet your needs at the lowest cost to you.

**Compound Drugs**

Compound Drugs over $400 require prior Authorization from MedImpact.

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

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

**Over-the-counter drugs**

Medications available over-the-counter in the same prescribed strength will no longer be covered under the pharmacy plan.
What is a formulary?

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

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

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

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

• Specialty medications – higher cost drugs.

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

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

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

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

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

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

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

4. Retirees with Medicare will be automatically enrolled in OGB’s Medicare Part D coverage with a commercial wrap benefit.
In addition, this Plan allows Benefits limited to $200.00 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are Medically Necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to Coinsurance and Copayments relating to Prescription Drug Benefits. In connection with this Benefit, the following words shall have the following meanings:

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

- Phenylketonuria (PKU)
- Maple Syrup Urine Disease (MSUD)
- Methylmalonic Acidemia (MMA)
- Isovaleric Adicemia (IVA)
- Propionic Acidemia
- Glutaric Acidemia
- Urea Cycle Defects
- Tyrosinemia

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

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

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

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

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

For more information on the pharmacy benefit, visit the MedImpact website at https://mp.medimpact.com/ogb or call MedImpact member services at 1-800-910-1831.
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.
SCHEDULE OF BENEFITS: Actives, Retirees Without Medicare, Retirees With Medicare

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

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

Benefit Period: .......................................................................................................................... 03/01/15 – 12/31/15

Deductible Amount Per Benefit Period:

**Individual:**

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

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

**Individual + 1 Dependent:**

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

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

**Family (Individual + 2 or more Dependents):**

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

Non-Network Providers:
Active Employees and Retirees on or after 3/1/15 (With and Without Medicare) $2,700.00
Retirees prior to 03/01/15 (With and Without Medicare) $900.00
**SPECIAL NOTES**

**Deductible Amounts**

**Active and Retirees on or after March 1, 2015:**

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

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

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

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

**Out-of-Pocket Maximum per Benefit Period:**

<table>
<thead>
<tr>
<th>Includes all eligible Copayments, Coinsurance Amounts and Deductibles</th>
<th>Active Employee/Retirees on or after March 1, 2015</th>
<th>Retirees prior to March 1, 2015 without Medicare</th>
<th>Retirees prior to March 1, 2015 with Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
<td>Network</td>
</tr>
<tr>
<td>Individual Only</td>
<td>$2,500</td>
<td>$3,700</td>
<td>$1,300</td>
</tr>
<tr>
<td>Individual Plus One (Spouse or Child)</td>
<td>$5,000</td>
<td>$7,500</td>
<td>$2,600</td>
</tr>
<tr>
<td>Individual Plus Two</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$3,900</td>
</tr>
<tr>
<td>Individual Plus Three</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$4,900</td>
</tr>
<tr>
<td>Individual Plus Four</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$5,900</td>
</tr>
<tr>
<td>Individual Plus Five</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$6,900</td>
</tr>
<tr>
<td>Individual Plus Six</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$7,900</td>
</tr>
<tr>
<td>Individual Plus Seven</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$8,900</td>
</tr>
<tr>
<td>Individual Plus Eight</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$9,900</td>
</tr>
<tr>
<td>Individual Plus Nine</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$10,900</td>
</tr>
<tr>
<td>Individual Plus Ten</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$11,900</td>
</tr>
<tr>
<td>Individual Plus Eleven or More</td>
<td>$7,500</td>
<td>$11,250</td>
<td>$12,700</td>
</tr>
</tbody>
</table>
SPECIAL NOTES

Out-of-Pocket Maximum

Active and Retirees on or after March 1, 2015:

Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket 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 to the Out-of-Pocket Maximum for Network Providers.

Retirees With Medicare Prior to March 1, 2015:

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

When the Out-of-Pocket 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.

Retirees Without Medicare Prior to March 1, 2015:

Eligible Expenses for services of a Network Provider that apply to the Deductible and Out-of-Pocket Maximum for Network Providers will count toward to 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 to the Out-of-Pocket Maximum for Network Providers.

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.

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

Eligible Expenses

Eligible Expenses are reimbursed in accordance with a fee schedule of maximum Allowable Charges, not billed charges.

All Eligible Expenses are determined in accordance with Plan Limitations and Exclusions.

Eligibility

The Plan Administrator assigns Eligibility to all Plan Participants.
## COINSURANCE

<table>
<thead>
<tr>
<th><strong>Active Employees/Non-Medicare Retirees</strong></th>
<th><strong>Retirees with Medicare</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network Providers</strong></td>
<td><strong>Non-Network Providers</strong></td>
</tr>
</tbody>
</table>

**Physician Office Visits including surgery performed in an office setting:**
- General Practice
- Family Practice
- Internal Medicine
- OB/GYN
- Pediatrics

| 90%-10%¹ | 70% - 30%¹ | 80% - 20%¹ |

**Allied Health/Other Professional Visits**
- Chiropractors
- Nurse Practitioners
- Retail Health Clinics
- Optometrist
- Osteopath
- Physician Assistants

| 90%-10%¹ | 70% - 30%¹ | 80% - 20%¹ |

**Specialist (Physician) Office Visits including surgery performed in an office setting.**
- Physician
- Podiatrist
- Midwife
- Audiologist
- Registered Dietician
- Sleep Disorder Clinic

| 90%-10%¹ | 70% - 30%¹ | 80% - 20%¹ |

**Ambulance Services - Ground**

| 90%-10%¹ | 70% - 30%¹ | 80% - 20%¹ |

**Ambulance Services - Air**

| 90%-10%¹,² | 70% - 30%¹ | 80% - 20%¹ |

**Ambulatory Surgical Center and Outpatient Surgical Facility**

| 90%-10%¹,² | 70% - 30%¹,² | 80% - 20%¹ |

**Autism Spectrum Disorders (ASD)**

| 90%-10%¹,³ | 70% - 30%¹,³ | 80% - 20%¹,³ |

**Birth Control Devices - Insertion and Removal**
*(As listed in the Preventive and Wellness Care Article in the Benefit Plan.)*

| 100% - 0% | 70% - 30%¹ | Network Providers 100% - 0%  
Non-Network Providers 80% - 20%¹ |

¹ Subject to Plan Year Deductible, if applicable
² Pre-Authorization Required, if applicable.
³ Not applicable for Medicare primary.
4 Age and/or Time Restrictions Apply
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Active Employees/Non-Medicare Retirees</th>
<th>Retirees with Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>Cardiac Rehabilitation (Must begin within six months of qualifying event)</td>
<td>90% -10%1,2,3</td>
<td>70% - 30%1,2,3</td>
</tr>
<tr>
<td>Chemotherapy/Radiation Therapy (Authorization not required if performed in Physician’s office.)</td>
<td>90% -10%1,2</td>
<td>70% - 30%1,2</td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>90% -10%1</td>
<td>70% - 30%1</td>
</tr>
<tr>
<td>Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities</td>
<td>90% -10%1</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dialysis</td>
<td>90% -10%1,2</td>
<td>70% - 30%1,2</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices</td>
<td>90% -10%1,2</td>
<td>70% - 30%1,2</td>
</tr>
<tr>
<td>Emergency Room (Facility Charge)</td>
<td>$150 Separate Deductible1; Waived if Admitted</td>
<td>90% -10%1</td>
</tr>
<tr>
<td>Emergency Medical Services (Non-Facility Charges)</td>
<td>90% -10%1</td>
<td>90% -10%1</td>
</tr>
<tr>
<td>Eyeglass frames and One pair of Eyeglass Lenses or One Pair of Contact Lenses (Purchased within 6 months following cataract surgery)</td>
<td></td>
<td>Eyeglass Frames - Limited to a Maximum Benefit of $501,3</td>
</tr>
<tr>
<td>Flu shots and H1N1 vaccines (Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older.)</td>
<td>90% -10%1,3</td>
<td>70% - 30%1,3</td>
</tr>
<tr>
<td>High-Tech Imaging – Outpatient</td>
<td>90% -10%1,2</td>
<td>70% - 30%1,2</td>
</tr>
</tbody>
</table>

1Subject to Plan Year Deductible, if applicable
2Pre-Authorization Required, if applicable. 
Not applicable for Medicare primary.
3Age and/or Time Restrictions Apply
## COINSURANCE

<table>
<thead>
<tr>
<th>Network Providers</th>
<th>Non-Network Providers</th>
<th>Network and Non-Network/Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Employees/Non-Medicare Retirees</strong></td>
<td><strong>Active Employees/Non-Medicare Retirees</strong></td>
<td><strong>Active Employees/Non-Medicare Retirees</strong></td>
</tr>
<tr>
<td><strong>Home Health Care (Limit of 60 visits per Plan Year)</strong></td>
<td>90% -10%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Hospice Care (Limit of 180 days per Plan Year)</strong></td>
<td>80% -20%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Injections Received in a Physician’s Office (When No Other Health Service is Received)</strong></td>
<td>90% -10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Admission, All Inpatient Hospital Services Included</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Per Day Copayment</strong></td>
<td>$0</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Day Maximum</strong></td>
<td>Not Applicable</td>
<td>5 Days</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>90% -10%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Inpatient and Outpatient Professional Services</strong></td>
<td>90% -10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Mastectomy Bras - Ortho-Mammary Surgical (Limit of three (3) per Plan Year)</strong></td>
<td>90% -10%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse - Inpatient Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Per Day Copayment</strong></td>
<td>$0</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Day Maximum</strong></td>
<td>Not Applicable</td>
<td>5 Days</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>90% -10%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse - Outpatient Treatment</strong></td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Newborn – Sick, Services Excluding Facility</strong></td>
<td>90% -10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Newborn – Sick, Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Per Day Copayment</strong></td>
<td>$0</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Day Maximum</strong></td>
<td>Not Applicable</td>
<td>5 Days</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>90% -10%&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible, if applicable

<sup>2</sup>Pre-Authorization Required, if applicable.

**Not applicable for Medicare primary.**

<sup>3</sup>Age and/or Time Restrictions Apply
<table>
<thead>
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</thead>
<tbody>
<tr>
<td></td>
<td>Network Providers</td>
<td>Non-Network Providers</td>
</tr>
<tr>
<td>Oral Surgery for Impacted Teeth (Authorization not required when performed in Physician’s Office)</td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;,&lt;sup&gt;2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;,&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pregnancy Care – Physician Services</td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness Care Article in the Benefit Plan.)</td>
<td>100% - 0%&lt;sup&gt;3&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;,&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Rehabilitation Services – Outpatient:</td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Speech</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical/Occupational (Combined limit of 50 Visits per Plan Year. Authorization required for visits over the combined limit of 50.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Visit limits do not apply when services are Provided for Autism Spectrum Disorders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility (Limit of 90 days per Plan Year)</td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;,&lt;sup&gt;2&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;,&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sonograms and Ultrasounds (Outpatient)</td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Vision Care (Non-Routine) Exam</td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>X-ray and Laboratory Services</td>
<td>90% - 10%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>70% - 30%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Subject to Plan Year Deductible, if applicable
<sup>2</sup>Pre-Authorization Required, if applicable.
<sup>3</sup>Not applicable for Medicare primary.
<sup>3</sup>Age and/or Time Restrictions Apply
ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

Authorization is Required Prior to Services Being Performed

Organ, Tissue and Bone Marrow Transplants and evaluation for a Plan Participant’s suitability for Organ, Tissue Bone Marrow transplants will not be covered unless a Plan Participant obtains written authorization from the Claims Administrator prior to services being rendered.

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

Active Employees and Non-Medicare Retirees:

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

Retirees with Medicare:

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

CARE MANAGEMENT

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

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

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

Authorization of Inpatient and Emergency Admissions

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered. The Plan Participant remains responsible for any applicable Copayment or Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.

If Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the penalty amount stipulated in the Provider’s contract with the other Blue Cross and Blue Shield plan. This penalty applies to all services and supplies requiring an Authorization. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the amount shown below. This penalty applies to all services and supplies requiring an Authorization. The Plan Participant is responsible for all charges not covered and for any applicable Copayment or Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits.
Additional Plan Participant responsibility if Authorization is not requested for an Inpatient Admission to a Non-Network Provider Hospital: **TWENTY-FIVE PERCENT (25%)** reduction of the Allowable Charges.

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

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

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.

**Authorization of Outpatient Services, Including Other Covered Services and Supplies**

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

If Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable. The Network Provider of the other Blue Cross and Blue Shield plan is responsible for all charges not covered. The Plan Participant remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

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

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

- Air Ambulance – Non-Emergency
- Applied Behavior Analysis
- Bone growth stimulator
- Cardiac Rehabilitation
- CT Scans
- Day Rehabilitation Programs
- Dialysis
- Durable Medical Equipment (Greater than $300.00)
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump
- Infusion Therapy (Exception: Infusion Therapy performed in a Physician’s office does not require prior Authorization. The Drug to be infused may require prior Authorization).
- Intensive Outpatient Programs
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician’s office)
• Organ Transplant Evaluation
• Orthotic Devices (Greater than $300.00)
• Outpatient surgical procedures not performed in a Physician’s office
• Outpatient non-surgical procedures (Exceptions: X-rays, lab work, Speech Therapy and Chiropractic Services do not require prior Authorization. Non-surgical procedures performed in a Physician’s office do not require prior Authorization).
• Outpatient pain rehabilitation or pain control programs
• Partial Hospitalization Programs
• PET/SPECT Scans
• Physical/Occupational Therapy (Greater than 50 visits)
• Prosthetic Appliances (Greater than $300.00)
• Residential Treatment Centers
• Sleep Studies
• Specialty Pharmacy (Complete list of drugs available online at www.bcbsla.com> I’m a Provider>Pharmacy Management>Specialty Pharmacy Program Drug List.pdf)
• Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
• Vacuum Assisted Wound Closure Therapy

Population Health – In Health: Blue Health

The Population Health program targets populations with one or more of these five(5) chronic health conditions – diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). (The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.) Through the In Health: Blue Health Services program, OGB offers an incentive to Plan Participants on Prescription Drugs used to treat the five chronic conditions listed above.

a. OGB Plan Participants participating in the program qualify for $0 Copayment for certain Generic Prescription Drugs approved by the U. S. Food and Drug Administration (FDA) for any of the 5 chronic health conditions.

b. OGB Plan Participants participating in the program qualify for $20 Copayment (31 day supply), $40 Copayment (62 day supply) or $50 Copayment (93 day supply) for certain Preferred Brand-Name Prescription Drugs.

c. OGB Plan Participants participating in the program qualify for $40 Copayment (31 day supply), $80 Copayment (62 day supply) or $100 Copayment (93 day supply) for certain Non-Preferred Brand-Name Prescription Drug. Non-Preferred drugs typically have lower cost alternatives available in the same drug class.

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

The In Health: Blue Health Services prescription incentive does not apply to any Prescription Drugs not used to treat one of these five health conditions with which you have been diagnosed. Please refer to the Care Management article, Population Health – In Health: Blue Health section of the Benefit Plan for complete information on how to qualify for this incentive.

PRESCRIPTION DRUGS

Prescription Drug Benefits are provided under the Hospital Benefits and Medical and Surgical Benefits Articles of the medical plan, and under the Pharmacy Plan provided by OGB’s Pharmacy Benefits Manager (sometimes “PBM”).

Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana provides Claims Administration services only for Prescription Drugs dispensed as follows:
Prescription Drugs Covered Under Hospital Benefits and Medical and Surgical Benefits

1. Prescription Drugs dispensed during an Inpatient or Outpatient Hospital stay, or in an Ambulatory Surgical Center are payable under the Hospital Benefits.

2. Medically necessary/non-investigational Prescription Drugs requiring parenteral administration in a Physician’s Office are payable under the Medical and Surgical Benefits.

3. Prescription Drugs that can be self-administered and are provided to a Plan Participant in a Physician’s office are payable under the Medical and Surgical Benefits.

Authorizations

The following Prescription Drug categories require Prior Authorization. The Plan Participant’s Physician must call 1-800-842-2015 to obtain Authorization. The Plan Participant or his Physician should call the Customer Service number on the back of the ID card, or go to the Claims Administrator’s website at www.bcbsla.com/ogb for the most current list of Prescription Drugs that require Prior Authorization:

- Growth hormones*
- Anti-tumor necrosis factor drugs*
- Intravenous immune globulins*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*

* Shall include all drugs that are in this category.

Therapeutic/Treatment Vaccines – Examples include, but are not limited to vaccines to treat the following conditions:

- Allergic Rhinitis
- Alzheimer’s Disease
- Cancers
- Multiple Sclerosis

Therapeutic/Treatment Vaccines

Network Provider: ................................................................. 100% - 0%
Non-Network Provider: .......................................................... 70% - 30% (After Deductible is Met)

OGB’S Pharmacy Benefits Manager

MedImpact Formulary: 3-Tier Plan Design*

OGB will begin using the MedImpact Formulary to help Plan Participants select the most appropriate, lowest-cost options. The formulary is reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. Plan Participants will continue to pay a portion of the cost of their prescriptions in the form of a copayment or coinsurance. The amount Plan Participants pay toward their prescription depends on whether they receive a generic, preferred brand or non-preferred brand name drug.

*These changes do not affect Plan Participants with Medicare as their primary coverage.
A formulary is a list of medications available to Plan Participants under the plan’s pharmacy benefit. Inclusion on the list is based on consideration of a medication’s safety, effectiveness and associated clinical outcomes. The formulary is updated regularly and divides drugs into four main categories: generic, preferred brand, non-preferred brand, and specialty.

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

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

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

- Specialty medications – higher cost drugs.

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

If a Plan Participant chooses a Brand-Name Drug for which an FDA-approved Generic version is available, the OGB Plan Participant pays the difference between the Brand-Name and Generic cost, plus a $40 Copayment for a 31 day supply.
2. Regardless of where the Prescription Drug is obtained, Eligible Expenses for Brand Name Drugs will be limited to:
   a. The Pharmacy Benefits Manager's maximum Allowable Charge for the Generic, when available; or
   b. The Pharmacy Benefits Manager's maximum Allowable Charge for the Brand Drug dispensed, when a Generic is not available.
   c. There is no per prescription maximum on the Plan Participant's responsibility for payment of costs in excess of the Eligible Expense. Plan Participant payments for such excess costs are not applied toward satisfaction of the annual Out-of-Pocket threshold (above).

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

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

5. In addition, this Plan allows Benefits limited to $200.00 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are Medically Necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to Coinsurance and Copayments relating to Prescription Drug Benefits. In connection with this Benefit, the following words shall have the following meanings:
   a. “Inherited metabolic disease” shall mean a disease caused by an inherited abnormality of body chemistry and shall be limited to:
      • Phenylketonuria (PKU)
      • Maple Syrup Urine Disease (MSUD)
      • Methylmalonic Acidemia (MMA)
      • Isovaleric Adicemia (IVA)
      • Propionic Acidemia
      • Glutaric Acidemia
      • Urea Cycle Defects
      • Tyrosinemia
   b. “Low protein food products” mean food products that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include natural foods that are naturally low in protein.

6. Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are not subject to the Prescription Drug deductible and are covered at 100%. Smoking cessation screening and counseling are covered under the Preventive or Wellness Care article of the Benefit Plan.
7. The following drugs, medicines, and related services and supplies are not covered:

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

For more information on the pharmacy benefit, visit the MedImpact website at [https://mp.medimpact.com/ogb](https://mp.medimpact.com/ogb) or call MedImpact member services at 1-800-910-1831.
Mental Health and Substance Abuse Benefits

What’s included as part of your OGB health plan?

Magellan Behavioral Health manages the mental health and substance abuse benefits that are part of your OGB health plan. You and your covered dependents can receive outpatient, inpatient, partial hospitalization and residential treatment for mental health and substance abuse problems with Magellan.

Here are some things you should know about Magellan and your benefits:

Getting the Best Care with Magellan’s Help

Magellan will help you get high-quality care with your needs in mind—giving you a better experience. By using Magellan, you get:

- **Care Management** – Magellan’s 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** – Magellan works with health plans and employers to understand your needs and to create treatment programs that will meet those needs.
- **High-Quality Care** – Magellan studies what care works best and compares results to help make your quality of care even stronger.

Network Providers

You can go to the Blue Cross Preferred Care behavioral health network of doctors and other mental health providers for your care for all plans except Magnolia Local. **Members in the Magnolia Local plan should access the Magellan behavioral health network of doctors and other mental health providers.**

Authorizations for Care

Magellan is responsible for all mental health and substance abuse care authorizations. Your doctor or provider must check with Magellan before you get care. This is true for all care, except outpatient care.

Learn More

Go online or call us to find out if your doctor is in your Blue Cross Preferred Care behavioral health network or to ask about your benefits:

**ONLINE:** [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb)

Under OGB Find Care:

Click **Mental Health Substance Abuse** to read more.

Click **Louisiana Provider Directory** to find a provider.

**CALL:**

Blue Cross Customer Service
1.800.392.4089
Monday – Friday
8 a.m. - 5 p.m.
How to Search for a Blue Cross 
Provider in Louisiana

To search for a Blue Cross provider within the 
state of Louisiana, go to www.bcbsla.com/ogb.

1. Click on “Louisiana Provider Directory” 
under OGB Find Care. This will bring you 
to the Doctor & Hospital Search page.

2. Step 1 is pre-populated with 
OGB Preferred Care (for all plans except 
Magnolia Local) in the box marked “Network.” To find a provider for 
Magnolia Local, select Community 
Blue or Blue Connect. To find a 
Magellan behavioral health 
provider for Magnolia Local, 
select Other Directories.

3. Step 2 allows you to enter a name, 
specialty, city, parish and/or ZIP 
code as the search criteria.

4. Click on the “Search” button.

5. You may refine your search 
results by Radius, Specialty, 
Parish, Availability, Gender, 
Admitting Hospitals and 
Board Certification.

6. To view your search results, you 
may sort by Distance, City A–Z, 
City Z–A, Name A–Z, Name Z–A or 
Number of Reviews. You may 
compare multiple providers by 
checking the box under “Compare.”

BCBSLA Mobile App

Our mobile app allows you to search for 
Louisiana providers while you’re on the go. 
Find urgent care or just look for directions to a 
network doctor near you.

Download the BCBSLA mobile app for iOS from 
your iPhone’s App Store. An Android version is 
coming soon!

Call Customer Service at 1.800.392.4089 
if you have any trouble locating a provider 
or if you have any questions. Customer 
Service is available 8 a.m. to 5 p.m., Monday 
through Friday.
Benefits That Travel

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

Please note: Magnolia Local members do not have access to the BCBS National BlueCard Providers.

How to Search for a National BlueCard® Provider

To search for a provider outside of the state of Louisiana, go to www.bcbsla.com/ogb and click on “National Provider Directory” under OGB Find Care.

1. This will bring you to the National Doctor and Hospital Finder.
2. To see doctors and hospitals in your network, enter “OGS” as the first three letters of your member ID.
3. Search for providers by name, specialty and radius. The page opens with your current location, or you may enter a different location.
4. Click on the “GO” button to continue.

National Doctor and Hospital Finder mobile apps are currently available on the iPhone and Android platforms. Free app downloads and more information can be found on www.bcbs.com/mobile/.

Call Customer Service at 1.800.392.4089 if you have any trouble locating a provider, or if you or your doctors have any questions. Customer Service is available 8 a.m. to 5 p.m., Monday through Friday.
All the Blue Cross plans offered are strengthened by our Care Management programs that ensure your care is appropriate. Our in-house team of doctors, nurses and pharmacists oversees our members’ care through the following functions:

**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 Care 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.

**Case Management**

Our Case Management Program, In Health: Blue Touch, works to coordinate the benefits with the physician’s care during and following an acute illness episode, including long-term goals for members with certain conditions. Through this program, we may often:

- Help resolve issues that block your path to good health
- Help you coordinate your healthcare services
- Serve as an advocate for your healthcare needs
- Give you educational materials and information about community-based resources
- Promote a healthy lifestyle

We will help you set positive healthcare goals and will coach you to reach them. Members may call **1.800.363.9159** for help with Case Management.

**Healthy Blue Beginnings**

This maternity support program provides information and confidential support before, during and after your pregnancy to help keep you and your baby healthy. This program is available at no extra cost and is open to members with potential for complicated pregnancies. We also offer support to help moms-to-be identify early warning signs of potential problems and special challenges. Members may call **1.800.363.9159** for more information about this program.

**Continuity of Care**

Under special circumstances such as a high-risk pregnancy or life-threatening illness, Blue Cross may allow members to continue receiving healthcare services from a non-network physician or other healthcare practitioner for a specified duration of time. Blue Cross members may request a Continuity of Care form by contacting Customer Service at **1.800.392.4089** or visiting [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb).
InHealth: Blue Health Services... Helping You Manage Today for a Healthier Tomorrow
Blue Cross and Blue Shield of Louisiana offers In Health: Blue Health Services—a health management program to help you if you have a chronic health condition.

At no additional cost to eligible members, In Health: Blue Health Services offers you health coaching, prescription incentives, educational materials and caring support.

Can you participate in the program?
As an OGB plan member, you can participate 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)

What can the program do for you?
• Learn more about your condition and how it affects you.
• Find out how to work with your doctor to manage or improve your health.
• Understand more about the medicines you take and why you take them.
• Receive health information that will help you understand, manage and improve your condition.

What is a health coach?
Our health coaches are Blue Cross nurses or healthcare professionals who:
• Give you individual support and attention;
• Help you set healthcare goals;
• Assist with coordinating your care;
• Serve as your advocates and advisors;
• Give you important health information;
• Help you find qualified physicians; and,
• Reduce the barriers to good health outcomes.

How can the program save you money on prescriptions?
• Pay only $20 (31-day supply), $40 (62-day supply) and $50 (93-day supply) for brand-name drugs when a generic is not available.
• Pay $0 for generic drugs for a 31-day supply of covered drugs.
• Covered drugs include certain drugs specifically prescribed for treating diabetes, coronary artery disease, heart failure, asthma and COPD.

How can you join the program?
Simply call our toll-free number at 1.800.363.9159 and speak with one of our Health Services Specialists, who can get you started.

We will assign you to a personal Blue Health Coach who will ask you a series of questions to assess your individual healthcare needs. Once that assessment is complete, together you and your Blue Cross Health Coach can plan to improve and maintain your overall health.
Give us a call. We’re here to help!
General and Specialist Care
If you need routine care, call your doctor and plan an office visit.

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 medical condition, 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 Discount Network
Members can take advantage of special discounts on dental services by simply presenting their ID card to a participating provider and immediately receiving significant savings.

To find a discount provider, visit www.bcbsla.com/ogb and under OGB Find Care, click on Louisiana Provider Directory. Next to Step 1, from the drop-down Network menu, choose Discount Dental.

Member ID Card
Blue Cross will issue two membership ID cards per family. Each ID card will list only the employee’s name, but can be used for all covered dependents. Your ID card also includes the following information:

- 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 1.800.392.4089 for a new ID card or email us at ogbhelp@bcbsla.com.

Your Right to Appeal
If you or your provider disagree with a clinical 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
Appeal and Grievance Unit
P.O. Box 98045
Baton Rouge, LA 70898-9045

If a member has questions or needs assistance putting the appeal in writing, he or she may call Customer Service at 1.800.392.4089.
My Account
Our members want more ways to manage their account and health information. That’s why we offer password-protected online tools that allow you to review and manage your healthcare information 24 hours a day, seven days a week.

To activate your online account, go to www.bcbsla.com/ogb and click LOG IN for instructions on how to register. If you need help registering or logging in, call the 24-hour support line at 1.800.821.2753.

Your online account tools help you manage your health with access to a summary of your benefits, claims activity, health education, self-care guides, treatment options, the Live Better Louisiana wellness program and discounts and deals.

Claims Review
See your latest plan activity or search past claims on the Claims screen:
• View your claims and the claims of covered dependents under 18.
• Easily see your costs in the highlighted columns.
• Search past claims by date, provider, etc.
• See claims payment status.
• Rate your doctor and write a review of a recent visit.

Online Health Tools
Use our free online health tools to learn your health risks and get help addressing them. You can also get a quick summary of past care for a new healthcare provider—or even an emergency.

Personal Health Assessment
The Personal Health Assessment (PHA) is an online questionnaire that allows you to learn any health risks you might face and prioritize an action plan to address them.

Blue Health Record
Your Blue Health Record provides a quick three-year summary of your medical care, based on claims and organized by episode of care.
• Moved to a new town? Give your new healthcare providers quick insight into any recent medical care.
• Evacuating from a hurricane? It may not seem likely, but your health record would be very useful in an emergency.
Health Education
It’s important to understand your health and stay informed about ways to improve it. That’s why Blue Cross provides an extensive online health library, as well as a video library with educational and entertaining videos on a number of health topics.
We also offer:
• **Preventive and Wellness Guides** to help you stay current with medical guidelines for specific ages and gender.
• **Health Condition Guides** for a selection of common illnesses and injuries, such as asthma, diabetes, heart disease, joint replacement, mental health, pain management and more.
• **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.

Discounts and Deals
Through our national association, we bring you Blue365®, a health and wellness program for members of participating local Blue Companies. Blue365 helps you save on a healthier lifestyle, with deals on gym memberships, healthy eating options, hearing and vision products, family activities and more.
Examples include:
• Exclusive $25/month membership to 8,000 gyms nationwide (*with three-month commitment*)
• 20% off all Reebok fitness gear, including shoes and apparel, plus free shipping
• 10-40% off Davis Vision products
• Discounts of 20-50% to a network of dentists

Mobile and Social Media
If you like to get health information online and interact with others, check out our social media accounts for wellness tips, recipes, breaking health news and more—as well as a sense of community. We’ve also got a mobile app for when you’re on the go.

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 iOS (Android version coming soon).

With your smart phone in hand, you can search for healthcare nearby using our Find a Doctor feature. Find urgent care if you need it, and get directions to doctors or hospitals. Already been to the doctor? Check out the status of your claim and see your costs and balances, right in the palm of your hand.

Social Hub
If you follow Facebook and Twitter, check out Blue Cross’ accounts on those services. On our social hub at *bcbsla.com/social*, you can access Blue Cross’ accounts on all of these social properties:
• **Facebook** (BlueCrossLA) offers daily health tips and news stories of interest to our membership.
• **Twitter** (@bcbsla) provides you with breaking news stories about health and healthcare.
• You can also follow our CEO, Mike Reitz (@MikeReitzCEO), our chief medical officer (@DrCarmouche) and our charitable giving foundation (@OurHomeLA) on Twitter.
• Watch our videos on *YouTube*, find health tips and infographics on *Pinterest*, or join us on *Flickr* or *Google+* as well—all connected easily from a central hub at *bcbsla.com/social*.

This is just the tip of the iceberg when you visit [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb) and log in. We are adding new tools and services all the time—so log in often!
Live Better Louisiana
Live Better Louisiana is OGB’s game plan for better health. The program gives Blue Cross plan members resources to help you better monitor your health, understand risk factors and make educated choices that keep you healthier. It’s sponsored by Blue Cross and Blue Shield of Louisiana at no extra charge to members.

Live Better Louisiana is a proactive approach—a way to prevent illness and to manage any conditions that do appear.

What's the Game Plan?
1. Fill out your Personal Health Assessment (PHA): This confidential online questionnaire provides you with a picture of your overall health and measures health risks and behaviors. It also gives you a personalized risk report and action plan for health improvement, with recommendations and access to the appropriate resources.

   How do I get there? If you have an online account, go to [www.bcbsla.com/mypha](http://www.bcbsla.com/mypha).
   
   If you haven’t yet activated your online account, go to [www.bcbsla.com/activate](http://www.bcbsla.com/activate).

2. Take your Preventive Onsite Health Checkup: Blue Cross has partnered with an industry leader, Catapult Health, to bring preventive checkups to sites near you all over the state. A calendar of events is available online where you can schedule a checkup with a licensed nurse practitioner and technician. You’ll get lab-accurate diagnostic tests and receive a full, printed Personal Health Report with checkup results and recommendations.

   How do I get there? Visit [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb) and then click the Live Better Louisiana Tab to download and review the onsite checkup flier with more details.


3. Take Charge of your Own Health with a Wealth of Resources: Live Better Louisiana gives you access to a wide range of healthy activities—some of which may even be suggested in your personal action plan. Blue Cross also brings OGB plan members a number of wellness-related deals and discounts.

   How do I get there? Explore the Live Better Louisiana tab at [www.bcbsla.com/ogb](http://www.bcbsla.com/ogb) and review your Personal Health Assessment. If your wellness checkup or PHA shows you are eligible for one of the Disease Management programs, a Blue Cross nurse will contact you.
In addition to Live Better Louisiana, all members have no-cost access to our My Health, My Way wellness program. The program includes:

- Interactive tools that let you track your weight, exercise and food intake.
- Fitness and nutrition plans that can be customized for you and your family.
- Online workshops on topics such as back care, nutrition, smoking cessation, stress management and weight management.
- Exclusive access to a national program, Blue 365®, providing savings on fitness club memberships, nutrition programs and products, financial well-being services, family care services and healthy travel. You can even save on elective procedures for vision and hearing.
- It’s all secure, confidential and at no extra cost to you!

Find out more at www.bcbsla.com/ogb under Benefits > Health & Wellness Tools.

**Louisiana 2 Step**

Louisiana ranks near the highest in the nation in adult obesity and in deaths from diabetes. These are some of the reasons why Blue Cross created the Louisiana 2 Step, a free and fun statewide public health education campaign to encourage all Louisianians to eat right and move more.

The award-winning interactive website, www.Louisiana2Step.com, brings this message to individuals and families. The 2 Step has tools and information to support your My Health, My Way wellness goals, such as local resources and Louisiana-style recipes.

**Security and Confidentiality:** The Personal Health Assessment has been engineered to provide the same level of protection for your confidential health information that online banking and consumer websites offer their clients and account-holders. If you are identified as someone who may benefit from Care Management Services, your information may be shared with medical personnel, and you may be contacted by a Care Management nurse. The information you provide in the PHA will be used only as permitted by law. This information will not adversely affect your enrollment in your health plan.
Blue365®

Living well means having healthy options every day. That’s why we offer Blue365® to take our members beyond health insurance and give you access to exclusive deals on trusted health and wellness resources—365 days a year. As a Blue Cross member, you enjoy special deals on many services from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more.

Blue365 is a national program that’s part of every plan, making it easier and more affordable to make healthy choices. If you choose to sign up, you’ll receive great health and wellness deals straight to your email inbox every week. And it’s easy to register. Just go to www.bcbsla.com/ogb and have your Blue Cross and Blue Shield of Louisiana member ID card handy. Click LOG IN to access your online account, then click Blue365 under Discounts and Deals.

Follow the instructions, and you’ll have access to two types of good-for-you deals: standing deals, which you can redeem any time you like, and exclusive, limited-time offers designed for living well—right in the moment.

Weekly Deals

Sign up for no-fuss emails, and you’ll be the first to know about the latest deals from Blue365. You won’t get any spam, and you’ll only get one email a week. You can also browse deals anytime on the Blue365 website. Take a look at some past offers in the following categories:

Health & Wellness

• Healthways – One of the most popular deals is Healthways Fitness Your Way, a program that gives you access to a network of 8,000+ gyms nationwide for only $25 per month and a low $25 enrollment fee. Participating Healthways gyms include Snap Fitness®, Curves® and more. Also, you get up to 30% off on more than 40,000 experienced health and well-being specialists, including massage therapists, personal trainers, nutrition counselors, yoga and Pilates instructors and more. Save on vitamins, exercise equipment, aromatherapy, organic products and unique gifts.

• Fitness – Blue365 offers other fitness deals as well, including discounts from Reebok, Polar Heart Rate Monitors, Body Media FIT and Walkadoo (pedometer-based activity program), plus savings on other types of health club memberships.

• Diet/Weight Control – Check out savings on programs, products and consultations at Jenny Craig and NutriSystem.

• Vision Discounts – With Blue365, our members can receive routine eye exams, frames, lenses, conventional contact lenses and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to more than 30,000 providers nationwide, including optometrists, ophthalmologists and many retail centers. Members can also save 40 to 50% off the overall national average price for Lasik surgery through QualSight LASIK and LASIK Plus.
Financial Health

- Refinance and Purchase Loans – Get cash back on qualified loans through Quicken Loans.
- Credit Monitoring – Save on identity theft and credit monitoring.

Family Care

- Programs for Kids – Save on kids’ wellness products, such as Brush Buddies and GeoPalz pedometers. Also, get access to child safety and consumer product information.
- Senior Care – Get discounts on care advisory services and eldercare support from organizations such as SeniorLink and CaringBridge.
- Long-Term Insurance – Locate free guidelines and information.
- Managing Medicare – Get resources to understand coverage options from Medicare.

Travel

- Healthy Getaways – Members can find savings on hotel programs, such as The Fairmont.
- Travel Tips – Explore a wealth of online travel tips and resources.

Members can browse all these healthy choices after logging in to My Account at www.bcbsla.com/ogb. Just click My Health, then Discounts.

Discounts for Non-covered Prescription Drugs

OGB members now have free access to a prescription coupon program that provides discounts on non-covered drugs—that is, medications not covered by your pharmacy benefits. The program is accepted at more than 56,000 pharmacies nationwide. Get more information, including pharmacy locations, by visiting www.bcbsla.com/ogb. Under OGB Find Care, click Non-covered Drug Discount Program.
**BALANCE BILLING DISCLOSURE**

Blue Cross and Blue Shield of Louisiana (BCBSLA) is required by law to provide the notice below to all members at the time of enrollment and annually. 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 of having your provider bill you for amounts in addition to applicable copayments, coinsurance, deductibles and non-covered services.

**BALANCE BILLING DISCLOSURE NOTICE:**

Healthcare Services may be provided to you at the 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 Copayments, 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](http://www.bcbsla.com) or by calling the Customer Service Telephone Number of your Health Plan: **1.800.392.4089**.