Louisiana

OGB
PELICAN HSA 775

COMPREHENSIVE CDHP MEDICAL BENEFIT PLAN
SCHEDULE OF BENEFITS

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

BENEFIT PLAN FORM NUMBER 40HR1697 R01/20

PLAN NAME	PLAN NUMBER
State of Louisiana Office of Group Benefits	ST222ERC
PLAN'S ORIGINAL EFFECTIVE DATE	PLAN'S ANNIVERSARY DATE
January 1, 2013	January 1st

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

Benefit Period: ..... 01/01/2020 – 12/31/2020

DEDUCTIBLE AMOUNT PER BENEFIT PERIOD

Network Providers -	
Individual	$2,000.00
Family	$4,000.00
Non-Network Providers -	
Individual	$4,000.00
Family	$8,000.00

SPECIAL NOTES

Deductible Amounts

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

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

COINSURANCE	Plan	Plan Participant
Network Providers	80%	20%
Non-Network Providers	60%	40%

OUT-OF-POCKET AMOUNT PER BENEFIT PERIOD

(Includes all eligible Medical and Pharmacy Coinsurance Amounts, Deductibles and/or Copayments)

Network Providers -

Individual	$5,000.00
Family	$10,000.00
Per Member Within a Family	$6,650.00

Non-Network Providers -

Individual	$10,000.00
Family	$20,000.00

SPECIAL NOTES

Out-of-Pocket Amount

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

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

When the Out-of-Pocket Amount, 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.

*If this Benefit Plan includes more than one (1) Plan Participant, the Individual Out-of-Pocket Amount is not applicable. The Family Out-of-Pocket Amount and Per Member within a Family Out-of-Pocket Amount applies.

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 for all Plan Participants.

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics • Geriatrics	80% - 20%[1]		60% - 40%[1]
Allied Health/Other Office Visits • Chiropractor • Retail Health Clinic • Nurse Practitioner • Physician Assistant	80% - 20%[1]		60% - 40%[1]
Specialist Office Visits including surgery performed in an office setting. • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietitian • Sleep Disorder Clinic	80% - 20%[1]		60% - 40%[1]
Ambulance Services - Ground	80% - 20%[1]		80% - 20%[1]
Ambulance Services – Air Non-emergency requires prior authorization[2]	80% - 20%[1]		80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20%[1]		60% - 40%[1]
Birth Control Devices - Insertion and Removal (*As listed in the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%		60% - 40%[1]
Cardiac Rehabilitation (*Must begin within six (6) months of qualifying event; Limited to 36 visits per Plan Year*)	80% - 20%[1,2,3]		60% - 40%[1,2,3]

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required
[3]Age and/or time restrictions apply

	NETWORK PROVIDERS		NON-NETWORK PROVIDERS
Chemotherapy/Radiation Therapy	80% - 20%[1]		60% - 40%[1]
Diabetes Treatment	80% - 20%[1]		60% - 40%[1]
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	80% - 20%[1]		Not Covered
Dialysis	80% - 20%[1]		60% - 40%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2]		60% - 40%[1,2]
Emergency Room (*Facility Charge*)	80% - 20%[1]		80% - 20%[1]
Emergency Medical Services (*Non-Facility Charge*)	80% - 20%[1]		80% - 20%[1]
Eyeglass frames and One pair of Eyeglass Lenses or One Pair of Contact Lenses (Purchased within six (6) months following cataract surgery)	Eyeglass Frames - Limited to a Maximum Benefit of $50.00[1,3]		Not Covered
Flu Shots and H1N1 vaccines (*Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%		100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*)	80% - 20%[1,3]		Not Covered
High-Tech Imaging – Outpatient (*CT Scans, MRI/MRA, Nuclear Cardiology, PET Scans*)	80% - 20%[1,2]		60% - 40%[1,2]
Home Health Care (*Limit of 60 Visits per Plan Year, Combination of Network and Non-Network) (One Visit = 4 hours*)	80% - 20%[1,2]		60% - 40%[1,2]
Hospice Care (*Limit of 180 Days per Plan Year, combination of Network and Non-Network*)	80% - 20%[1,2]		60% - 40%[1,2]

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required
[3]Age and/or time restrictions apply

	NETWORK PROVIDERS		NON-NETWORK PROVIDERS
Injections Received in a Physician's Office (*When no other health services is received*)	80% - 20%[1]		60% - 40%[1]
Inpatient Hospital Admission (*All Inpatient Hospital services included*)	80% - 20%[1,2]		60% - 40%[1,2]
Inpatient and Outpatient Professional Services	80% - 20%[1]		60% - 40%[1]
Interpreter Expenses for the Deaf or Hard of Hearing	100% - 0%		100% - 0%
Mastectomy Bras - Ortho-Mammary Surgical (*Limited to three (3) per Plan Year*)	80% - 20%[1]		60% - 40%[1]
Mental Health/Substance Use Disorder - Inpatient Treatment and Intensive Outpatient Programs	80% - 20%[1,2]		60% - 40%[1,2]
Mental Health/Substance Use Disorder – Office Visits and Outpatient Treatment (Other than Intensive Outpatient Programs)	80% - 20%[1]		60% - 40%[1]
Newborn – Sick, Services excluding Facility	80% - 20%[1]		60% - 40%[1]
Newborn – Sick, Facility	80% - 20%[1,2]		60% - 40%[1,2]
Oral Surgery	80% - 20%[1,2]		60% - 40%[1,2]
Pregnancy Care – Physician Services	80% - 20%[1]		60% - 40%[1]
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness/ Routine Care Article in the Benefit Plan*.)	100% - 0%[3]		100% - 0%[3]

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required
[3]Age and/or time restrictions apply

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational [2] (*Limit of 50 Visits combined PT/OT per Plan Year. Authorization required for visits over the combined limit of 50.*) (*Visit limits are combination of Network and Non-Network Benefits*; *Visit limits do not apply when services are provided for Autism Spectrum Disorders.*)	80% - 20%[1]		60% - 40%[1]
Skilled Nursing Facility (*Limit of 90 days per Plan Year*)	80% - 20%[1,2]		60% - 40%[1,2]
Sonograms and Ultrasounds - Outpatient	80% - 20%[1]		60% - 40%[1]
Urgent Care Center	80% - 20%[1]		60% - 40%[1]
Vision Care (Non-Routine) Exam	80% - 20%[1]		60% - 40%[1]
X-Ray (Low-Tech Imaging) and Laboratory Services	80% - 20%[1]		60% - 40%[1]

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required
[3]Age and/or time restrictions apply

ORGAN AND BONE MARROW TRANSPLANTS

Authorization is required prior to services being rendered.

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

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

CARE MANAGEMENT

Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4089.

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

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

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

Authorization of Inpatient and Emergency Admissions

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information.

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.

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

If a Non-Network Provider fails to obtain a required Authorization, the Claims Administrator will reduce the Coinsurance to **50% - 50%**. 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.

The following Admissions require Authorization prior to the services being rendered or supplies being received.

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

NOTE: Emergency services (life and limb threatening emergencies) received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands with a BlueCard® Worldwide provider are covered at the Network Benefit level. Non-emergency services received outside of the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands from a non-BlueCard® Worldwide provider **are covered at the Non-Network Benefit level.**

Authorization of Outpatient Services and Supplies

If a Blue Cross and Blue Shield of Louisiana Network Provider fails to obtain a required Authorization, no Benefits are payable. The Network Provider is responsible for all charges not covered.

If a Network Provider in another Blue Cross and Blue Shield plan fails to obtain a required Authorization, no Benefits are payable unless the procedure is deemed Medically Necessary. If the procedure is deemed Medically Necessary, the Plan Participant remains responsible for his applicable Deductible and Coinsurance percentage. If the procedure is not deemed Medically Necessary, the Plan Participant is responsible for all charges incurred.

If a Non-Network Provider fails to obtain a required Authorization, Benefits are reduced to **50% - 50%** Coinsurance. The Plan Participant is responsible for all charges not covered and remains responsible for his Deductible and Coinsurance.

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

- Air Ambulance – Non-Emergency (no Benefit without prior Authorization)
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- CT Scans
- Day Rehabilitation Programs

- Durable Medical Equipment (greater than $300.00)
- Electric & Custom Wheelchairs
- Gene Therapy
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00, including but not limited to defibrillators and insulin pumps
- Infusion Therapy – includes home and facility administration (exception: Physician's office, unless the drug to be infused may require authorization)
- Intensive Outpatient Programs
- Low Protein Food Products
- MRI/MRA
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician's office)
- Orthotic Devices (greater than $300.00)
- 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)
- Pulmonary Rehabilitation
- Residential Treatment Centers
- Sleep Studies (except those performed as a home sleep study)
- Transplant Evaluation and Transplants
- Vacuum Assisted Wound Closure Therapy

Population Health – In Health: Blue Health

The Population Health program targets populations with one or more chronic health conditions. The current chronic health conditions identified by OGB are diabetes, coronary artery disease, heart failure, asthma and chronic obstructive pulmonary disease (COPD). OGB may supplement or amend the list of chronic health conditions covered under this program at any time. (The In Health: Blue Health Services program is not available to Plan Participants with Medicare primary.)

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

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

b. OGB Plan Participants participating in the program qualify for $15.00 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 $15.00 Brand-Name Copayment.

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

PRESCRIPTION DRUGS

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 Amount and applicable Copayments:

$10.00 Copayment per 31 day supply – Generic (Up to a 93 day supply/3 Copayments)
$25.00 Copayment per 31 day supply – Preferred Brand (Up to a 93 day supply/3 Copayments)
$50.00 Copayment per 31 day supply – Non-Preferred Brand (Up to a 93 day supply/3 Copayments)
$50.00 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.

Proprotein convertase subtilisin/kexin type 9 (PCSK-9) inhibitors (e.g. Praluent®, Repatha™) are excluded.

Benefits are available for contraceptive drugs.

Therapeutic/Treatment Vaccines are subject to payment of Deductible Amount and Coinsurance percentage.

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

As currently provided in the Benefit Plan's Prescription Drug Utilization Program, in some cases the Company may require the Plan Participant to first try one or more Prescription Drug to treat a medical condition before the Company will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Plan Participant's medical condition, the Company may require the Plan Participant's Physician to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Company 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 Drug included in the Step Therapy program without first trying a Step A 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** 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