Louisiana

OGB
PELICAN HRA 1000

COMPREHENSIVE CDHP MEDICAL BENEFIT PLAN
SCHEDULE OF BENEFITS

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

BENEFIT PLAN FORM NUMBER 40HR2031 R01/25

PLAN NAME
State of Louisiana Office of Group Benefits

PLAN NUMBER
ST222ERC

PLAN'S ORIGINAL EFFECTIVE DATE
January 1, 2013

PLAN'S ANNIVERSARY DATE
January 1st

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

Benefit Period: .....01/01/2025 – 12/31/2025

DEDUCTIBLE AMOUNT PER BENEFIT PERIOD:

	Network Providers	**Non-Network Providers**
Individual	$2,000.00	$4,000.00
Family	$4,000.00	$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.

To the extent required by federal law, cost sharing for Non-Emergency Services performed by Non-Network Providers at Network facilities will be at the Network level and based on the recognized amount.

COINSURANCE

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

OUT-OF-POCKET MAXIMUM PER BENEFIT PERIOD:

WHEN OGB IS THE PRIMARY PAYER FOR ALL PLAN PARTICIPANTS

Includes all eligible Copayments, Coinsurance Amounts, and Deductibles		
	Network Providers	**Non-Network Providers**
Individual	$5,000.00	$10,000.00
Family	$10,000.00	$20,000.00
Per Member Within a Family	$6,850.00	N/A

WHEN MEDICARE IS THE PRIMARY PAYER FOR AT LEAST ONE PLAN PARTICIPANT

Includes all eligible Copayments, Coinsurance Amounts, and Deductibles		
	Network Providers	**Non-Network Providers**
Individual	Medical: $3,000.00 Prescription: $2,000.00	$10,000.00
Family (Medicare Paying Primary for One)	Medical: $8,000.00 (Per Member Within a Family $6,850) Prescription: $2,000.00	$20,000.00
Family (Medicare Paying Primary for Two)	Medical: $6,000.00 Prescription: $2,000.00	$20,000.00
Family (Medicare Paying Primary for Three)	Medical: $4,000.00 Prescription: $2,000.00	$20,000.00
Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.		

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.

To the extent required by federal law, cost sharing for Non-Emergency Services performed by Non-Network Providers at Network facilities will be at the Network level and based on the recognized amount.

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.

*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 • Midwives • 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 • Audiologist • Registered Dietitian • Sleep Disorder Clinic	80% - 20%[1]		60% - 40%[1]
Ambulance Services - Ground			
Emergency Ground Ambulance Services In-State	80% - 20%[1]		80% - 20%[1]
Emergency Ground Ambulance Services Out-of-State	80% - 20%[1]		80% - 20%[1]
Non-Emergency Ground Ambulance Services	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]
Bariatric Surgery Services			
• Facility Services	$2,500.00 Copayment[2,3]		No Coverage
• Professional Services	90% -10%[2,3]		No Coverage
• Preoperative and Postoperative Medical Services	80% - 20%[2,3]		No Coverage
NOTE: No Benefits will be payable unless Prior Authorization is obtained, including Plan Participants with Medicare as the Primary Plan.			

[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.

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; Limit of 36 visits per Plan Year*).	80% - 20%[1,2,3]		60% - 40%[1,2,3]
Chemotherapy/Radiation Therapy	80% - 20%[1]		60% - 40%[1]
Diabetes Treatment	80% - 20%[1]		60% - 40%[1]
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 Services – Outpatient Imaging Services: (*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, **if applicable.**
[2]Pre-Authorization Required, **if applicable**.
Not Applicable for Medicare Primary.
[3]Age and/or time restrictions apply.

Injections Received in a Physician's Office (*When no other health service 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]
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]

[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.

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, **if applicable**.
[2]Pre-Authorization Required, **if applicable**.
Not Applicable for Medicare Primary.
[3]Age and/or time restrictions apply.

ORGAN AND BONE MARROW TRANSPLANTS

Authorization is Required Prior to Services Being Performed

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

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, We 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 services is NOT a guarantee of payment. Penalty amounts do not accrue to the Out-of-Pocket Amount.

Authorization for Inpatient and Emergency Admissions

Inpatient Admissions ad Emergency Admissions must be Authorized. Refer to Care Management Article and if applicable the Pregnancy Care and Newborn Care Benefits Article of the Benefit Plan for complete information. Request for Authorization of Inpatient Admissions, Emergency Admissions, and for Concurrent Review of an Admission in progress 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.

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. 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 any applicable 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
- Arterial Ultrasound*
- Arthroscopy and Open Procedures (Shoulder & Knee)*
- Bariatric Surgery Benefit (Enrollment & Surgery)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Coronary Arteriography*
- CT Scans
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than $300.00)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic or Molecular Testing
- Hip Arthroscopy*
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (including but not limited to defibrillators)
- Infusion Therapy – includes home and facility administration (exception: Physician’s office, unless the drug to be infused may require Authorization)
- Intensive Outpatient Programs
- Interventional Spine Pain Management*
- Joint Replacement (Hip, Knee, & Shoulder)*
- Low Protein Food Products
- MRI/MRA
- Meniscal Allograft Transplantation of the Knee*
- Nuclear Cardiology
- Oral Surgery (not required when performed in a Physician’s office)
- Orthotic Devices (greater than $300.00)
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions (such as Coronary Stents and Balloon Angioplasty)*
- PET Scans
- Physical/Occupational Therapy (greater than 50 visits)
- Prosthetic Appliances (greater than $300.00)
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology*
- Residential Treatment Centers

- Resting Transthoracic Echocardiography*
- Sleep Studies, (except those performed as a home sleep study)
- Spine Surgery*
- Stress Echocardiography*
- Surgical Treatment of Urinary Dysfunction or Sexual Dysfunction Resulting from Cancer or Cancer Treatment (Including penile implants)
- Transesophageal Echocardiography*
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects*
- Vacuum Assisted Wound Closure Therapy

*Part of the MSK (Pain, Spine, Joint), Radiation Oncology and Cardiac Programs

Population Health – In Health: Blue Health

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

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

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

b. OGB Plan Participants participating in the program qualify for $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

Prescription Drug Benefits are provided under the Hospital Benefits and Medical and Surgical Benefits Articles of the medical plan, and under the pharmacy benefit programprovided 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 visit Our 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

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

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

OGB'S Pharmacy Benefits Manager

CVS Caremark Formulary: 4-Tier Plan Design

OGB's Pharmacy Benefit Manager for the 2025 Plan year is CVS Caremark. OGB will use the CVS Caremark Formulary to help Plan Participants select the most appropriate, lowest-cost options. The Formulary is reviewed on at least a quarterly basis to re-assess drug tiers based on the current prescription drug market. Plan Participants will continue to pay a portion of the cost of their prescriptions in the form of a Copayment or Coinsurance. The amount Plan Participants pay toward their prescription depends on whether they receive a generic, preferred brand or non-preferred brand name drug. You must use drugs on the Formulary to qualify for pharmacy benefits under the Plan.

PRESCRIPTION DRUG	PLAN PARTICIPANT PAYS
Generic	50% up to $30.00
Preferred	50% up to $55.00
Non-Preferred	65% up to $80.00
Specialty	50% up to $80.00
The pharmacy out-of-pocket threshold is $1,500.00. Once met:	
Generic	$0 co-pay
Preferred	$20.00 co-pay
Non-Preferred	$40.00 co-pay
Specialty	$40.00 co-pay

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

For more information on the pharmacy benefit, visit Express Script's website at **www.caremark.com** or **https://info.groupbenefits.org** or call CVS Caremark member services at 1-877-300-1906, 1-888-996-0104 (EGWP), or Pharmacy Help Desk at 1-800-364-6331.