Changes to your OGB coverage

Effective August 1, members will see some changes to their medical and pharmacy plans. For full details about your coverage, please review your plan document. Some of the changes effective August 1 include:

BLUE CROSS BLUE SHIELD OF LOUISIANA – PPO, HMO, CDHP

Prior Authorization Requirements
OGB will begin requiring prior authorization for certain medical procedures and services. A prior authorization is a process used to determine the necessity of a proposed service or procedure and is a standard measure for managing health care plans. BCBSLA will send healthcare providers a list of the required prior authorizations. Your provider is familiar with this process and has all the information needed to request your medical service be reviewed and approved for coverage. To avoid extra costs always ask your healthcare provider to request a prior authorization before you have a planned medical service.

Some services* that will now require a prior authorization:

- Cardiac rehabilitation
- CT scans
- Genetic testing
- Home health care
- Hospice
- MRI/MRA
- Orthotic Devices
- Outpatient pain rehabilitation/Pain control programs
- Physical /Occupational Therapy
- Residential treatment centers
- Inpatient hospital admissions (except routine maternity stays)

Speech therapy will no longer require a pre-authorization.

*A complete list of services and procedures requiring prior authorizations is available at www.bcbsla.com/ogb.

Application of Standard Benefit Limits
OGB will now follow the BCBSLA standard for number of visits allowed per benefit period for skilled nursing facilities, home health care services and hospice care services. This will be standard across all OGB plans.

- Skilled Nursing Facility — 90 days per benefit period
- Home Health Care Services — 60 days per benefit period
- Hospice Care Services — 180 days per benefit period

Visit www.bcbsla.com/ogb for more information.

PHARMACY –

MedImpact Formulary: 3-Tier Plan Design
OGB will begin using the MedImpact Formulary to help members 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. Members will continue to pay a portion of the cost of their prescriptions in the form of a co-pay or co-insurance. The amount members pay toward their prescription depends on whether they receive a generic, preferred brand or non-preferred brand name drug.

	Current Benefit	August 1 Benefit
Generic	50% up to $50	50% up to $30
Preferred	50% up to $50	50% up to $55
Non-Preferred	50% up to $50	65% up to $80
Specialty	50% up to $50	50% up to $80
The pharmacy deductible has been changed from $1,200 to $1,500. Once met:		
Generic	$0 co-pay	$0 co-pay
Preferred	$15 co-pay	$20 co-pay
Non-Preferred	$15 co-pay	$40 co-pay
Specialty	$15 co-pay	$40 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.

90-day fill option
For maintenance medications, 90-day prescriptions fills may be filled at retail pharmacies for two and half times the cost of your co-pay.

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

For more information on these pharmacy changes, visit MedImpact's website.