BlueCross BlueShield of Louisiana

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OGB

MAGNOLIA OPEN ACCESS

COMPREHENSIVE PPO MEDICAL BENEFIT PLAN
SCHEDULE OF BENEFITS

Nationwide Network Coverage
Preferred Care Providers and BCBS National Providers

BENEFIT PLAN FORM NUMBER 40HR1695 03/15

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

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:

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

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 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.

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

	ACTIVE EMPLOYEES/NON-MEDICARE RETIREES		RETIREES WITH MEDICARE
	Network Providers	Non-Network Providers	Network and Non-Network/Providers
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.**
Not applicable for Medicare primary.
[3]Age and/or Time Restrictions Apply

COINSURANCE

	ACTIVE EMPLOYEES/NON-MEDICARE RETIREES		RETIREES WITH MEDICARE
	Network Providers	Non-Network Providers	Network and Non-Network/Providers
Cardiac Rehabilitation (*Must begin within six months of qualifying event)*	90%-10%[1,2,3]	70% - 30%[1,2,3]	80% - 20%[1,3]
Chemotherapy/Radiation Therapy (*Authorization not required if performed in Physician's office.*)	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Diabetes Treatment	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	90% -10%[1]	Not Covered	80% - 20%[1]
Dialysis	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Emergency Room (*Facility Charge*)	$150 Separate Deductible[1]; Waived if Admitted		
	90% -10%[1]	90% -10%[1]	80% - 20%[1]
Emergency Medical Services (*Non-Facility Charges*)	90% -10%[1]	90% -10%[1]	80% - 20%[1]
Eyeglass frames and One pair of Eyeglass Lenses or One Pair of Contact Lenses (*Purchased within 6 months following cataract surgery*)	Eyeglass Frames - Limited to a Maximum Benefit of $50[1,3]		
Flu shots and H1N1 vaccines (*Administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%	100% - 0%	100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*)	90% -10%[1,3]	70% - 30%[1,3]	80% - 20%[1,3]
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET/SPECT Scans	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Home Health Care (*Limit of 60 visits per Plan Year*)	90% -10%[1,2]	70% - 30%[1,2]	Not Covered
Hospice Care (*Limit of 180 days per Plan Year*)	80% -20%[1,2]	70% - 30%[1,2]	Not Covered
Injections Received in a Physician's Office (*When No Other Health Service is Received*)	90% -10%[1]	70% - 30%[1]	80% - 20%[1]

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

COINSURANCE

	ACTIVE EMPLOYEES/NON-MEDICARE RETIREES		RETIREES WITH MEDICARE
	Network Providers	Non-Network Providers	Network and Non-Network/Providers
Inpatient Hospital Admission, All Inpatient Hospital Services Included			
Per Day Copayment	$0	$50	$0
Day Maximum	Not Applicable	5 Days	Not Applicable
Coinsurance	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Inpatient and Outpatient Professional Services	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Mastectomy Bras - Ortho-Mammary Surgical (*Limit of three (3) per Plan Year*)	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Mental Health/Substance Abuse - Inpatient Treatment			
Per Day Copayment	$0	$50	$0
Day Maximum	Not Applicable	5 Days	Not Applicable
Coinsurance	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Mental Health/Substance Abuse - Outpatient Treatment	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn – Sick, Services Excluding Facility	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn – Sick, Facility			
Per Day Copayment	$0	$50	$0
Day Maximum	Not Applicable	5 Days	Not Applicable
Coinsurance	90% -10%[1,2]	70% - 30%[1,2]	80% - 20%[1]

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

COINSURANCE

	ACTIVE EMPLOYEES/NON-MEDICARE RETIREES		RETIREES WITH MEDICARE
	Network Providers	Non-Network Providers	Network and Non-Network/Providers
Oral Surgery for Impacted Teeth (*Authorization not required when performed in Physician's Office*)	90% 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Pregnancy Care – Physician Services	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness Care Article in the Benefit Plan.)	100% -0%[3]	70% - 30%[1,3]	Network - 100% - 0[3] Non-Network 80% - 20%[1,3]
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational (*Combined limit of 50 Visits per Plan Year. Authorization required for visits over the combined limit of 50.)* *(Visit limits do not apply when services are Provided for Autism Spectrum Disorders)*	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Skilled Nursing Facility *(Limit of 90 days per Plan Year)*	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Sonograms and Ultrasounds (*Outpatient*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Urgent Care Center	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Vision Care (Non-Routine) Exam	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
X-ray and Laboratory Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]

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

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.

PRESCRIPTION DRUG	PLAN PARTICIPANT PAYS
Generic	50% up to $30
Preferred	50% up to $55
Non-Preferred	65% up to $80
Specialty	50% up to $80
The pharmacy out-of-pocket maximum has been changed from $1,200 to $1,500. Once met:	
Generic	$0 co-pay
Preferred	$20 co-pay
Non-Preferred	$40 co-pay
Specialty	$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.

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 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** or call MedImpact member services at 1-800-910-1831.