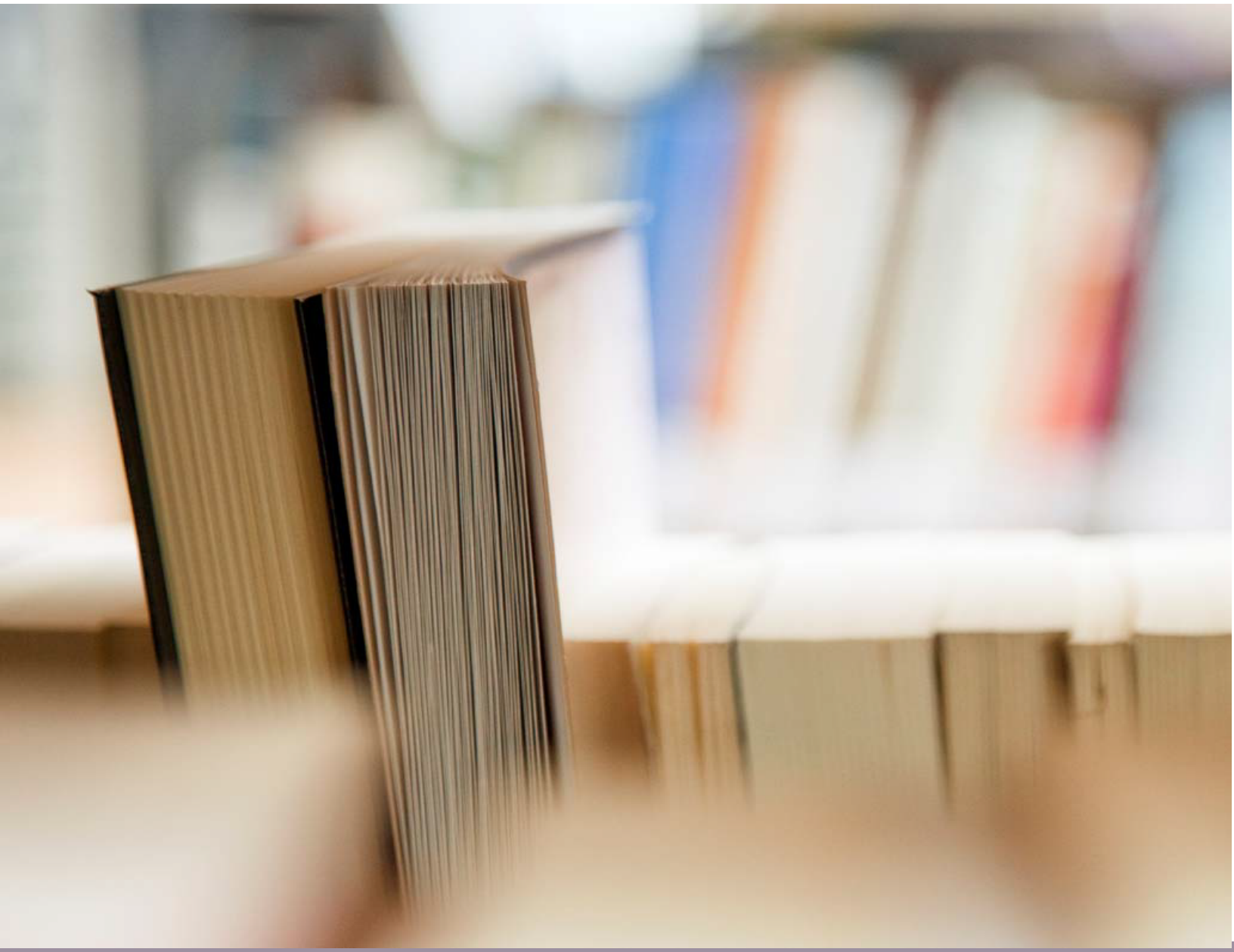
Louisiana State University Health Sciences Center New Orleans

2023-2024 Student Health Plan Benefit Guide



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MEDICAL BENEFITS OVERVIEW

Blue Cross and Blue Shield of Louisiana is proud to serve the healthcare needs of LSUHSC students. 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
- Prenatal care
- Preventive and wellness services
- Pharmacy benefits
- Mental health counseling
- Substance abuse services
- Online tools to help you get the most from your health plan
- An ID card recognized across the globe
- Local customer service

ELIGIBILITY

A registered student, fellow or post-doctoral fellow, domestic or international student who is enrolled in a participating college/program and actively attending classes for at least thirty-one (31) days after the effective date of coverage under this benefit plan. International and domestic students must purchase the Basic Blue Plan or provide proof of comparable coverage to the LSU Health Sciences Center. House officers, fellows and post-doctoral fellows actively attending classes may purchase the plan on a voluntary basis. Coverage will become invalid for students who leave school within 31 days of their effective date of coverage. The servicing agent should be notified at that time by the student. Students who enroll in the plan may secure family coverage. Eligible dependents must enroll in the plan when the student first enrolls in the plan, and must enroll for the same coverage as the student.

Newly born infants will be covered automatically for thirty (30) days from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to his/her home, whichever is longer, provided that the covered parent has notified AJ Gallagher of the birth of the Child.

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COVERAGE PERIODS

Enrollment Period

Full-time domestic and international students must provide proof of comparable coverage or purchase an insurance plan offered through LSUHSC within 30 days of the effective date of coverage for their particular college/program. All other students and dependents must submit a completed enrollment form and the proper premium to the servicing agent within 30 days of the effective date of coverage for their particular college/program. If enrollment does not occur within the periods specified, students and eligible dependents will only be permitted to enroll within 31 days of involuntary loss of group coverage under another insurance plan, marriage or birth or adoption of child.

Effective and Expiration Dates

The coverage effective and expiration dates for each college/program are listed below. Coverage is subject to eligibility and premium payment requirements.

COLLEGE/PROGRAMS:

SEMI-ANNUAL COVERAGE PERIODS

FALL

College/Program	Effective Date	Expiration Date
Allied Health	07-01-23	12-31-23
School of Dentistry	07-01-23	12-31-23
Graduate Studies	07-01-23	12-31-23
School of Medicine	07-01-23	12-31-23
School of Nursing	07-01-23	12-31-23
Resident/Post Grads	07-01-23	12-31-23
School of Public Health	07-01-23	12-31-23

SPRING

College/Program	Effective Date	Expiration Date
Allied Health	01-01-24	06-30-24
School of Dentistry	01-01-24	06-30-24
Graduate Studies	01-01-24	06-30-24
School of Medicine	01-01-24	06-30-24
School of Nursing	01-01-24	06-30-24
Resident/Post Grads	01-01-24	06-30-24
School of Public Health	01-01-24	06-30-24

SUMMER ONLY COVERAGE PERIOD

NEWLY ENROLLED STUDENTS ONLY

College/Program	Effective Date	Expiration Date
Allied Health	05-01-24	06-30-24
School of Dentistry	05-01-24	06-30-24
Graduate Studies	05-01-24	06-30-24
School of Medicine	05-01-24	06-30-24
School of Nursing	05-01-24	06-30-24
Resident/Post Grads	05-01-24	06-30-24
School of Public Health	05-01-24	06-30-24

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BLUE CROSS GIVES YOU COVERAGE WHEN -AND WHERE- YOU NEED IT MOST

You can't predict when you might need to visit a doctor or pharmacy. That's why Blue Cross gives you access to healthcare at home and abroad.

Network Benefits

Blue Cross members may access the Preferred Care network of doctors, hospitals and allied healthcare professionals. Network providers will submit your claims for you. To find a Blue Cross doctor or hospital nearby, visit **www.bcbsla.com** and click on **FIND A DOCTOR**.

Your Student Health Centers offer several convenient campus locations where you may receive network benefits, including:

- Physician office visits
- Preventive and treatment options
- Pharmacy services
- Mental health counseling
- Substance abuse services

Care Away From Home

If you're outside of Louisiana and need medical care, your benefits travel with you. Your Blue Cross plan is part of a single electronic network linking Blue Cross and Blue Shield plans across the nation – and in more than 200 countries and territories worldwide. To locate a doctor or hospital outside of Louisiana, visit **www.bcbsla.com/findcare** or call the BlueCard Access line at **800.810.BLUE (2583).**

CUSTOMER SERVICE

ONLINE: www.bcbsla.com

BY PHONE: 800.495.BLUE(2583)

Student Health Clinics

3700 St. Charles Ave.
New Orleans, LA 70112
All services available
by appointment or walk-in
8:00 a.m. to 11:30 a.m. and 1:00 p.m. to 4:30 p.m.
Monday - Friday
Phone: 504.412.1366

478 S. Johnson St.
New Orleans, LA 70112 Nursing services available
Call for M.D. availability
8:00 a.m. to 4:30 p.m.
Monday - Friday
Phone: 504.412.1517

Student Health Services

Seton Building 3rd Floor
478 S. Johnson St.
New Orleans, LA 70112
8:00 a.m. to 4:30 p.m.
Monday - Friday
Phone: 504.412.1517

About BlueCare

BlueCare is Blue Cross and Blue Shield of Louisiana's telehealth platform, which lets you have online visits with medical and behavioral health providers using a computer, smartphone, tablet or any device with internet and a camera.

BlueCare is covered for all individual and fully insured group members and their covered dependents. Self-funded employer groups can decide whether or not to offer telehealth benefits, which will include BlueCare, to their members and their covered dependents.

MEDICAL VISITS

BlueCare is available 24/7 to give patients more access to doctors. BlueCare is faster, easier and less expensive than going to an ER or urgent care for minor health needs. BlueCare can be useful for treating non-emergency, minor conditions like:

- Sinus infections
- Bladder infections
- Allergies
- Cold or cough
- Fever
- Vomiting, diarrhea
- Flu symptoms
- Rashes
- Pink eye

BEHAVIORAL HEALTH VISITS

Online appointments are available for behavioral health needs, including depression, grief, stress, life transitions, anxiety, couples' counseling and more. Customers can log in and schedule a visit with a psychology or psychiatry provider who is trained and certified in telehealth care.

BLUECARE COST AND CONVENIENCE

For any type of visit, BlueCare customers will be able to see what it will cost before the online visit begins. This depends on their plan type and benefits. Customers can use any major credit card, and even HSA or FSA cards, to pay for BlueCare visits. Their card will not be charged until they've had the visit.

Customers can also use BlueCare to get a prescription, to check in with a doctor if they need a follow-up visit, or when traveling. BlueCare providers can give work or school absence excuses by request. BlueCare providers are available in all 50 states. BlueCare meets state and federal healthcare services laws, is HIPAA compliant and is as legitimate as an in-person visit.

SIGNING UP IS EASY

Customers can go to **www.BlueCareLA.com or download the BlueCare (one word) app from the Apple Store or Google Play for iOS and Android tablets and smartphones.** To connect to BlueCare, the customer will create a login ID and password from a computer or mobile device. Once logged onto BlueCare, customers can see which providers are available for online visits and choose the provider they want to see.

Questions about BlueCare

Who can use BlueCare?

If you are an individual member, which means you buy your own health insurance and do not get it through your job, you can use BlueCare.

If you get your insurance through work or another group, it depends on the services and benefits covered on your plan. If your health insurance is provided through your employer, ask your Human Resources department if BlueCare is covered on your group plan.

Your covered dependents (spouse, children, etc.) can use BlueCare if it's one of the benefits for your plan.

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ONLINE HEALTH & WELLNESS EDUCATIONAL TOOLS

With ***Blue Cross and Blue Shield of Louisiana*** you can get the resources you need to commit to healthier, happier living.

Explore the ***Wellness*** section to find:

- **Wellness Discounts offered through Blue 365** – Special savings for Blue Members on services like:
  - Fitness club memberships
  - Athletic wear and gear
  - Diet and weight-control programs
  - Laser vision correction
  - Hearing care and senior care

- **Wellness Support** – Find a schedule that reminds you of the preventive health screenings you should have at every age to stay on top of your health. Also, explore a listing of events and resources in your region.

To access more Blue365 information, visit **www.blue365deals.com/BCBSLA**

ACTIVATE YOUR ONLINE ACCOUNT

You can register for an online account by visiting **www.bcbsla.com/activate.**

To register, you will need your Member ID number (found on your Member ID card) and a secure Personal Identification Number (PIN). If you have not received a PIN in the mail, or you have lost yours, you can request a new one at the second step of the registration process.

Blue Cross provides telephone support for users who need help with their online account registration process, including holidays and weekends. So if you need any help registering or logging in, you can call toll-free **800.821.2753** any time.

Remember this is only support for the registration process. If you need help with your benefits or claims, please call the Customer Service number on your Blue Cross ID card.

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MEDICAL SUMMARY OF BENEFITS

Administered by Blue Cross and Blue Shield of LA

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way-especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	BASIC BLUE PLAN	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited	
Annual Deductible - Aggregate	$0 Individual $0 Family	$1,000 Individual $3,000 family
Annual Out-of-Pocket Maximum	$2,500 Individual $5,000 Family	$5,000 individual $10,000 family
Coinsurance	100%	70%
OFFICE VISITS AND PREVENTATIVE CARE		
Physician Office Visit	$25 copay per visit	Deductible then 30%
Allied Health Office Visit	$25 copay per visit	Deductible then 30%
Quality Blue Primary Care (QBPC)	$10 Primary Care copay per visit	Not Available
Specialist Office Visit	$40 copay per visit	Deductible then 30%
Wellness Visit	$0 copay per visit - 100%	Deductible then 30%
Lab and Low Tech X-Ray (Includes Independent Facility)	Plan pays 100%	Deductible then 30%
High Tech X-Ray Services (Includes Independent Facility)	Plan pays 100%	Deductible then 30%
OUTPATIENT SERVICES PERFORMED AT AN OUPATIENT FACILITY		
Facility Charges	$350 copay	Deductible then 30%
Professional Services	Plan pays 100%	Deductible then 30%
Lab and X-Ray	Plan pays 100%	Deductible then 30%
INPATIENT SERVICES (NON-PARTICIPATING HOSPITAL PENALTY WILL ALSO APPLY)		
Hospital	$350 per day for the first (3) days of admission	Deductible then 30% + Non-Participating Penalty
Professional Services	Plan pays 100%	Deductible then 30%
OTHER COVERED SERVICES		
Prenatal Visits and Delivery	$40 copay per pregnancy	Deductible then 30%
Emergency Room	$350 copay per visit / waived if admitted	
Urgent Care	$40 copay per visit	Deductible then 30%
Speech Therapy (Excludes Inpatient)	$25 copay per visit	Deductible then 30%
Physical/Occupational Therapy (Excludes Inpatient)	$25 copay per visit	Deductible then 30%
Ambulance Service	$50 copay per day per provider	Deductible then 30%
Prosthetic Appliances & Orthotic Devices	Plan pays 80%	Deductible then 30%
Durable Medical Equipment	Plan pays 80%	Deductible then 30%
BENEFITS THAT REQUIRE AUTHORIZATION (DOES NOT INCLUDE LIST OF OUTPATIENT SERVICES OR DRUGS REQUIRING AUTHORIZATION)		
Organ and Tissue Transplants	Plan pays 100%	Not Available
Skilled Nursing Facility	Plan pays 100%	Deductible then 30%
Home Health	Plan pays 100%	Deductible then 30%
Hospice	Plan pays 100%	Deductible then 30%

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PRESCRIPTION DRUG BENEFITS

Administered by Blue Cross and Blue Shield of LA

There are two ways to fill your prescriptions:

1. Bring your prescription to a network pharmacy and pay one copayment to cover up to a 30- or 90-day supply (or manufacturer's recommended dosage); or
2. For maintenance drugs and the convenience of mail order delivery, you pay a copayment equal to three times the retail copayment for up to a 90-day supply (or manufacturer's recommended dosage).

PRESCRIPTION DRUG COVERAGE			
Tier Level	Description	Retail Copay (up to 30-day supply)	Mail Order Copay (up to 90-day supply)
Tier 1	Primarily generic drugs, although some brand-name drugs may fall into this tier	$7	$21
Tier 2	Primarily brand-name drugs, although some generic drugs may fall into this tier	$30	$90
Tier 3	Brand-name or generic drugs that may have a therapeutic alternative as a Tier 1 or Tier 2 drug; covered compounded drugs are included in this tier	$70	$210
Tier 4	A prescription drug that is a multi-source brand drug	10% Specialty with $150 maximum	

Questions About Your Prescription Drug Coverage?

Create an online account

- Visit the Express Scripts, Inc. at www.express-scripts.com

Call Express Scripts

- Customer Service at 1-866-781-7533 or the Pharmacy number on your ID card

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NEEDLESTICK BENEFIT

Administered by Blue Cross and Blue Shield of LA

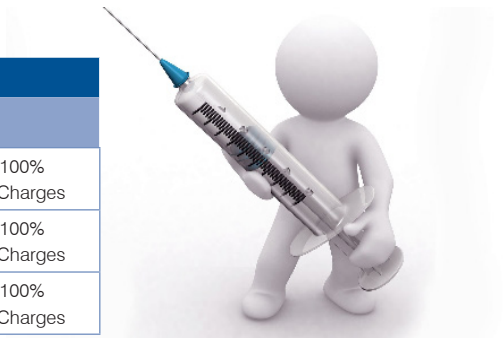
Needlestick injuries that expose students to blood-borne pathogens are an important public health concern and Blue Cross Blue Shield of Louisiana offers a separate Needlestick benefit, which is available on the Basic Blue Plan or as a standalone option. This benefit provides coverage for eligible students for testing and prophylactic treatment of blood borne diseases following **at-risk contact** with blood or other bodily fluids from human or animal sources. The contact must include and is limited to needlesticks. This benefit will cover 100% of the Blue Cross and Blue Shield of Louisiana Allowable Charge for the physical evaluation, physician office visit, student health clinic, outpatient facility, Hepatitis and HIV Antibody and Antigen tests, and an initial round of Hepatitis B vaccine. This Benefit Plan does not cover inpatient admission, additional or follow-up testing or treatment not specific to needlesticks, antiviral or antibiotic treatments or pharmacy benefits outside of those specifically listed under the Prescription Drug Benefit section of this Schedule of Benefits. **Emergency Room visits are not covered under the needlestick contract.** Please see your benefit plan for details, limitations and exclusions. Students who have Medicaid as their primary insurance must present both their needlestick card and their Medicaid card to ALL medical providers.

In the case of a needlestick injury, please visit BCBSLA's website at www.bcbsla.com for all in-network providers and facilities.

PRESCRIPTION DRUG BENEFITS

Administered by Blue Cross and Blue Shield of LA

	NEEDLESTICK BENEFIT	
Hepatitis/HIV Antibody/Antigen Tests and Vaccines	Plan pays 100%	Plan pays 100% of Allowable Charges
Lab Work	Plan pays 100%	Plan pays 100% of Allowable Charges
Outpatient Facility Charges	Plan pays 100%	Plan pays 100% of Allowable Charges



The needlestick policy offers coverage per occurrence when a student has experienced a needlestick injury. The needlestick policy identification card that students receive in the mail includes information necessary to process pharmacy claims in the event of a needlestick injury.

Bring your prescription to an in-network pharmacy. Please go to www.bcbsla.com to find an in-network pharmacy.

Covered drugs are Prophylaxis Drugs, Truvada and lsentress.

- To be prescribed when a student has come in contact with a potentially contaminated needle during the course of their training.
- Covered at 100%; There is no member cost share.
- Benefit is limited to a 3-day supply per occurrence.

LSUHSC Students are to report the needlestick incident to LSUHSC Student Health at 504.525.4839 or email studenthealthstaff@lsuhsc.edu.

A SPECIAL NOTE ABOUT MEDICAID

Students who have Medicaid as their primary insurance must present both their needlestick card and their Medicaid card to the pharmacy for ALL prescriptions. If you have Medicaid and you're filling a prescription not related to a needlestick injury and your prescription is denied, have the pharmacy run your BCBSLA Needlestick ID card and deny the charge and then run the prescription with your Medicaid card or other private insurance ID card.

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MEDICAL & NEEDLESTICK PLAN COSTS

MEDICAL PLAN PREMIUMS - Blue Cross and Blue Shield of LA			
	FALL	**SPRING**	**SUMMER (2 MONTHS)** New Students Only
Student Only	**$3,216.34**	**$3,216.34**	**$1,072.11**
Spouse	**$3,216.28**	**$3,216.28**	**$1,072.09**
Child/Children	**$2,733.82**	**$2,733.82**	**$911.27**
Spouse & Child/Children	**$5,950.16**	**$5,950.16**	**$1,983.39**
NeedleStick Benefit	**$16.54**	**$16.54**	**$5.51**

TO ENROLL FOR STUDENT ONLY COVERAGE IN THE MEDICAL OR NEEDLESTICK PLANS, PLEASE CONTACT THE BURSAR'S OFFICE AT LSUHSC N.O.

TO ENROLL IN THE MEDICAL OR NEEDLESTICK PLANS

STUDENTS

If you want to enroll in the medical or needlestick plan, all LSUHSC N.O. students need to apply through the LSUHSC N.O. Bursar's Office at **NOBURSAR@LSUHSC.EDU** or **504-568-4694**.

FELLOWS & HOUSE OFFICERS

To enroll in coverage for the medical or needlestick plans, please contact our local partner Gallagher Benefit Services at lsu.hsc.gbs@ajg.com or 225-906-1227.

ELIGIBLE DEPENDENTS

To enroll in coverage for dependent medical coverage, please contact our local partner Gallagher Benefit Services at **lsu.hsc.gbs@ajg.com** or **225-906-1227**.

Please note that you must enroll your dependents within 30 days of the effective date of coverage for your specific program, and you must pay the total premium due through the end of the current academic term upon enrollment. Dependents may not be covered at any time unless you are also covered.

Please refer to page 3 for a list of programs and effective dates. If enrollment doesn't occur within those 30 days following the effective dates, you will only be allowed to enroll your dependents within 31 days of an involuntary loss of group coverage or a qualifying life event.

QUESTIONS?

If you have any questions about enrollment or benefits in any of the plans in this brochure, please contact Gallagher Benefit Services at **lsu.hsc.gbs@ajg.com** or call **225-906-1227**.

QR CODE

Please scan the QR Code to download all Registration Forms

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DENTAL BENEFITS

UnitedHealthcare

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with **LSUHSC N.O.** voluntary dental benefit plan.

Contract Year Deductible Per Member / Per Family	$50 / $150 Not Applied to Diagnostic & Preventive Services	
Annual Benefit Maximum Per Member (In-Network & Out-of-Network, Class A, B, C)	$1,000	
Carryover Benefit	$250 (Threshold Limit $500, Carryover Account Maximum $1,000)	
	CONTRACT PAYS	
CLASS A - DIAGNOSTIC & PREVENTIVE CARE	IN NETWORK	OUT OF NETWORK
Routine Oral Exams and Cleanings	90%	90%
Bitewing X-Rays (once a year)		
Fluoride Treatments (children under 16 only)		
Full Mouth X-Rays (once every 2 years)		
CLASS B - BASIC SERVICES		
Basic Restorative (Fillings)	80%	80%
Simple Extractions		
CLASS C - MAJOR CARE (12 MONTH WAITING PERIOD)		
Endodontics (Root Canals)	50%	50%

*This is a brief description of your benefits for illustrative purposes only. Please refer to your schedule of benefits for more information.

To Find a Dentist:

- **Visit www.myuhc.com / Click Find a Dentist / then click Employer and Individuals Plans / then enter your zip code / or call UHC at 877.816.3596**

VISION BENEFITS

UnitedHealthcare

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone. Keep your eyes healthy with **LSUHSC N.O.** voluntary vision benefit plan.

	In Network	Out of Network
COPAYMENTS (12 MONTHS FREQUENCY)		
Eye Examinations	$15 copay	Up to $40 allowance
Materials (Lenses and/or Frames)	$15 copay	N/A
EYEGLASS BENEFIT - FRAMES (12 MONTHS FREQUENCY)		
Frame	$130 Retail Allowance	up to $45 allowance
EYEGLASS BENEFIT - SPECTACLE LENSES (12 MONTHS FREQUENCY)		
Lenses (Single, Bifocal, Trifocal)	Included	up to $40, $60, $80 allowance
Lenticular Lens Upgrade	Included	up to $80 allowance
Progressive Lens Upgrade	Tier 1: $55	up to $80 allowance
CONTACT LENS BENEFIT (IN LIEU OF EYEGLASSES) (12 MONTHS FREQUENCY)		
Elective Contact Lenses	Formulary Up to 4 boxes	up to $125 allowance
Medically Necessary Contact Lenses (with prior approval)	Included	up to $210 allowance

*This is a brief description of your benefits for illustrative purposes only. Please refer to your schedule of benefits for more information.

Laser Vision Correction - UnitedHealthCare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

To Find a Vision Provider:

- **Visit www.myuhc.com / Click Find a Vision Provider / then click Employer and Individual Plans / then enter your zip code / or call UHC at 800.638.3120**

UnitedHealthCare Dental and Vision members will no longer receive physical ID cards.

Dental and Vision Digital ID cards are available on www.myuhc.com and the UnitedHealthcare app.

A Vision only member can set up access to view their benefits and print an ID card at www.myuhcvision.com.

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VOLUNTARY DENTAL & VISION PLAN COSTS

DENTAL PLAN PREMIUMS - VOLUNTARY - UnitedHealthCare				
	ANNUAL	FALL	SPRING	SUMMER (2 MONTHS)
Student Only	$314.28	$157.14	$157.14	$52.38
Student + One	$628.44	$314.22	$314.22	$104.74
Student + Two or More	$1,116.48	$558.24	$558.24	$186.08

VISION PLAN PREMIUMS - VOLUNTARY - UnitedHealthCare				
	ANNUAL	FALL	SPRING	SUMMER (2 MONTHS)
Student Only	$114.84	$57.42	$57.42	$19.14
Student + One	$218.40	$109.20	$109.20	$36.40
Student + Two or More	$368.04	$184.02	$184.02	$61.34

TO ENROLL IN THE VOLUNTARY DENTAL OR VISION PLAN

Gallagher Student Health & Special Risk (GSH) a division of Arthur J. Gallagher, will manage the Voluntary Dental & Vision online enrollment process.

Go to https://www.gallagherstudent.com/lsu-no and select "Louisiana State University - HSC New Orleans" to go to our landing page. Select "Dental/Vision Enroll" in the top left menu. Complete the online enrollment form and then select your method of payment: e-check or credit card.

You need to enroll yourself and your dependents within 30 days of the effective date of coverage for your specific program. Please refer to page 3 for a list of programs and effective dates.

For more detailed benefit information, select "Plan Highlights" and select the plus (+) sign next to UnitedHealthCare Vision and Dental.

QUESTIONS? Contact lsu.hsc.gbs@ajg.com or 225-906-1227.

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MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

Coverage for Mental Health & Substance Abuse Care is paid the same as, or better than any other illness.

Mental Health Counseling

- Emotional Difficulties
- Stress
- Substance Abuse

COPAYMENTS

A copayment is a fixed dollar amount that you pay for a covered service or prescription drug. Copayments are available for most services in the network. These copayment amounts are detailed throughout this booklet and in your benefit plan.

DEDUCTIBLES AND COINSURANCE

A benefit period is defined as a calendar year: January 1 through December 31. For new members, your benefit period begins on your effective date of coverage and ends on December 31.

You pay a coinsurance, which means your costs are shared with Blue Cross. Once you have reached your annual out-of-pocket maximum, Blue Cross will pay 100 percent of the allowable charges for your covered benefits. Please see your benefit plan for specific details on your deductible, coinsurance percentage and annual maximums.

OUT-OF-NETWORK BENEFITS

If you receive care outside of the Preferred Care PPO network, you will first have to meet the $1,000 out-of-network deductible ($3,000 for families), then pay a percentage of the remaining balance for most services.

URGENT CARE BENEFITS

There may be instances when you need non-emergency medical care after hours. This is referred to as "urgent care." Examples of urgent care include, but are not limited to: colds and flu, sprains, stomachaches and nausea. Urgent care centers offer extended office hours to patients on an unscheduled basis without the need for an appointment.

EMERGENCY CARE BENEFITS

As always, in emergency situations the first priority is to seek treatment at the nearest facility. Please call your physician within 48 hours after seeking emergency treatment. Authorization for an emergency inpatient admission must be requested within 48 hours of hospital admission.

PREVENTIVE CARE

Blue Cross is committed to preventive care. Detecting illnesses in their earlier stages ensures better health for our members and reduces medical costs for everyone. To promote preventative care, Blue Cross plans cover a full array of wellness services

The Patient Protection and Affordable Care Act brought changes to the healthcare industry. The list below is a sample of preventive services available to our customers and their enrolled dependents at no out-of-pocket cost when obtained from a network provider.

Network Care:

- $0 copayment for one routine physical exam
- Routine gynecological exams
- Pap smear
- Routine mammography exam, if ordered by a physician
- Well-baby care for dependent children
- Immunizations recommended by a physician
- Prostate (PSA) screening test
- Routine hemoccult (colon) test for adult men and women
- Lab and low-tech X-ray services covered at 100 percent
- Vision impairment screening

QUALITY BLUE PRIMARY CARE (QBPC)

To maximize and improve healthcare services delivered to their customers, Blue Cross is working closely with primary care doctors in our network and making your health information – like medical claims for treatment - available so your doctor has a fuller picture of your health and history when you go in for appointments. This saves you time and effort, so you can spend office visits talking with your doctor about your needs or questions.

You'll get help and coaching to be as healthy as you can be: Between appointments, you can talk with a Blue Cross nurse who will be your health coach, help you stick to your care plan and give you the support you need to achieve your health goals.

You have a team behind you: Blue Cross collaborates with your QBPC doctor's office, working together to improve your health and help you stay on top of your wellness.

To find out if your doctor is enrolled in QBPC, you can check the online provider directory, where BCBSLA has a blue "Q" to show which doctors are participating. Quality Blue Primary Care (QBPC) doctor's will charge you a cheaper copayment of $10 each visit.

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NOTICE OF PLAN CHANGES FOR 2023

Digital Health Benefit - Remote Patient Therapy -The Digital Health Benefit is currently covered today. This benefit will be updated to enhance the delivery and reimbursement to ensure appropriate use of remote patient therapy, including remote patient monitoring. Remote patient therapy, including remote patient monitoring, is the collection and electronic transmission of biometric data in accordance with a treatment plan for chronic and/or acute health conditions. This benefit complements Telehealth services and relies on the offering of virtual encounters.

A**ddition of Pediatricians to the Quality Blue Program** - Pediatricians will now be included in the QB program. If your plan currently has a reduced copay for QB Providers, pediatricians who participate in the QB program will now qualify for this reduced copay.

S**afe Harbor Drug Program Language Revision** - If your plan currently includes the Safe Harbor Drug Program, language in the Schedule of Benefits is being revised to provide flexibility for the inclusion of certain Brand-Name and Generic drugs to the program. To verify your plan's pharmacy benefits, please refer to your plan's Schedule of Benefits.

Durable Medical Equipment (DME), Orthotic Devices, Prosthetic Appliances and Devices (Limb and Non-Limb) - Coverage of Durable Medical Equipment (DME), Orthotic Devices, Prosthetic Appliances and Devices (Non-Limb), and Prosthetic Appliances and Devices and Prosthetic Services of the Limbs has been revised to reflect there is no coverage for repair, adjustment or replacement of equipment, appliances, or devices when provided under warranty or when the equipment, appliance, or device is subject to a recall.

Limit on Cost Share for Insulins – Act 724 (HB 677) - Applicable member cost share for covered insulin prescriptions processed under the pharmacy benefit will be capped at $75 per fill for a 30-day supply to comply with Act 724. To verify your plan's pharmacy benefits, please refer to your plan's Schedule of Benefits.

Prescription Donor Human Breast Milk – Act 489 (HB 651) - Outpatient benefits will be updated to provide up to two months of coverage per lifetime for donor human breast milk upon prescription of the Member's treating Provider for each covered infant (birth up to 12 months of age). Benefits are subject to any applicable copayments, deductibles, and/or coinsurance depending on your plan. Donor human breast milk must be obtained from a member bank of the Human Milk Banking Association of North America or other source approved by Blue Cross.

Outpatient Private Duty Nursing Limits - Outpatient Private Duty Nursing is a covered benefit and will now be limited to 400 hours per benefit period.

Additions and Changes to Preventive Services - The ACA requires preventive and wellness service coverage for the following items and services:
U.S. Preventive Services Task Force (USPSTF) recommendation with a rating of 'A' and 'B'; immunizations for routine use in children, adolescents and adults with a recommendation from the Advisory Committee on Immunization Practices (ACIP); for infants, children and adolescents, preventive care and screenings provided in guidelines supported by the Health Resources and Services Administration (HRSA); and for women, preventive care and screenings provided in guidelines supported by HRSA which are currently published by the Women's Preventive Services Initiative (WPSI). These preventive and wellness services will be covered at no cost to members when rendered by a Network provider. The services listed below will be added to and/or revised in policies for 2023. Additional services may be added as required by law and may include enhancements to existing services.

WPSI:

- **Preventing Obesity in Midlife Women** - Coverage is now available for counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.
- **Contraception** - Coverage is available for adolescent and adult women to have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve birth outcomes. Contraceptive care includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period). Contraceptive care also includes follow-up care (e.g., management, evaluation and changes, including the removal, continuation, and discontinuation of contraceptives). Coverage is available for the full range of U.S. Food and Drug Administration (FDA) - approved, -granted, or -cleared contraceptives, effective family planning practices, and sterilization procedures as part of contraceptive care. This is an update to the existing mandate. Notably, a requirement that contraceptive methods be female-controlled has been removed.
- **Breastfeeding Services and Supplies** - Coverage is available for comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding. Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services. This is an update to the existing mandate.
- **Screening for Human Immunodeficiency Virus Infection (HIV)** - Coverage is available for all adolescent and adult women, ages 15 and older, to receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk, and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. WPSI recommends risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk. A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission. This is an update to the existing mandate.
- **Counseling for Sexually Transmitted Infections (STIs)** - Coverage is available for directed behavioral counseling by a health care clinician or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for STIs. WPSI recommends that clinicians review a woman's sexual history and risk factors to help identify those at an increased risk of STIs. Risk factors include, but are not limited to, age younger than 25, a recent history of an STI, a new sex partner, multiple partners, a partner with an STI, and a lack of or inconsistent condom use. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgment. This is an update to the existing mandate.
- **Well-Woman Preventive Visits** - Coverage is available for women to receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure the provision of all recommended preventive services, including preconception and many services necessary for prenatal and interconception care, are obtained. The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors. These services may be completed at a single visit or as a part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, and risk factors. Well-woman visits also include prepregnancy, prenatal, postpartum and interpregnancy visits. This is an update to the existing mandate.
- **Additions and Changes to Coverage Governed by the 2023 Notice of Benefit and Payment Parameters (NBPP)** - The 2023 Notice of Benefit & Payment Parameters (NBPP) released April 28, 2022 by the Centers for Medicare and Medicaid Services (CMS) contains numerous previsions related to health coverage. The following set forth the changes that are being made to the contents of plan documents (benefit plans and/or schedules of benefits) as a result of regulatory guidance in the 2023 NBPP.

  Limitation on Hearing Aid Coverage Based on Age – Part 156.125 of Affordable Care Act (ACA) prohibits age limitations on medically necessary hearing aids covered as an Essential Health Benefit (EHB) even where the age limit is established by state law. Currently, hearing aids are covered up to age 17. This limitation will be removed. Prior Authorization may apply.

  Limitation of Applied Behavior Analysis (ABA) Therapy Coverage Based on Age – Part 156.125 of Affordable Care Act (ACA) prohibits age limitations on Autism Spectrum Disorder (ASD) benefits even where the age limit is established by state law. ASD coverage is available for all ages. Currently, Applied Behavior Analysis (ABA) therapy is covered up to age 21. This age limitation on ABA therapy will be removed. Prior Authorization may apply.

  Limitations on Coverage of Certain Services and Treatment of the Foot Based on Diagnosis (Whether Diabetes or Another Underlying Medical Condition) – Part 156.125 of Affordable Care Act (ACA) prohibits limitations on coverage of certain services, treatments, or procedures of the foot based on diagnosis. Currently, some services, treatments, or procedures for the foot (cutting or removal of corns and calluses, nail trimming, or debriding) are covered for Members with a diabetes diagnosis. The requirement that a person have a diabetes diagnosis to receive such services, treatments, or procedures will be removed. All eligible Members will be able to receive six (6) services, treatments, or procedures for cutting or removal of corns and calluses, nail trimming, or debriding per benefit period regardless of diagnosis.

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EASY-TO-READ SBC DOCUMENT HELPS YOU UNDERSTAND YOUR BENEFITS

As part of the health care reform law, the government established a health plan information document called the Summary of Benefits and Coverage (SBC). The SBC will help you understand and compare different medical plan options. It provides an overview of each medical plan in a standard format and is written in easy-to-understand language. The SBC for this group plan, Premier Blue Copay 100/70, is available at **http://producers.bcbsla.com/sbc**

The Summary of Benefits and Coverage includes three parts:

Benefits and coverage information

This section includes a chart that lists the main features of your medical plan option(s). It answers fundamental questions about the coverage levels of the plan options. It also provides specific information about coverage for different services, such as office visits, prescription drugs and emergency room services.

Coverage examples

The coverage examples on the last two pages of the document show how the plan might cover medical care for three specific scenarios – "Having a Baby," and "Managing Type 2 Diabetes," and "Simple Fracture." The examples show what the plan would pay and what the patient would pay based on a common set of assumptions. It is important to note that these are examples only. They should not be used to estimate your actual costs under the plan.

A link to a Uniform Glossary

The SBC explains how to access or request a glossary with definitions for common health insurance and medical terms, such as copayment and deductible. There may be differences between terms found in the Uniform Glossary and those in your health plan documents. In these instances, you should go by the terms in your health plan document.

This benefit summary prepared by

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